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## **National Electronic Data Interchange Transaction Set Implementation Guide**

# **Health Care Claim: Professional**

# **837**

**ASC X12N 837 (004010X098A1)**

*October 2001 • NPRM Draft*

Contact **Washington Publishing Company** for more Information.

**1.800.972.4334**

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# 1 Introduction to Modified Pages

This document is addenda to the X12N Health Care Claim: Professional Implementation Guide, originally published May 2000 as 004010X098. As a result of the post publication review process, items were identified that could be considered impediments to implementation. These items were passed to the X12N Health Care Work Group that created the original Implementation Guide for their review.

Appropriate modifications make up the contents of this Draft Addenda to the X12N 004010X098 Implementation Guide published in May 2000. Since this guide is named for use under HIPAA, this is a Draft Addenda that will go through a Notice of Proposed Rule Making (NPRM) process, just as the original Implementation Guide did, before becoming a final addenda to the guide published by X12N. Only the modifications noted in this Draft Addenda will be considered in the NPRM. Once this Draft addenda is approved for publication by X12N, the value used in GS08 will be "004010X098A1".

Each of the changes made to the 004010X098 Implementation Guide have been annotated with a note in red and a line pointing to the location of the change. For convenience, the affected 004010X098 Implementation Guide page number is noted at the bottom of the page. Please note that as a result of insertion or deletion of material each addenda page may not begin or end at the same place as the original referenced page. Because of this, addenda pages are not page for page replacements and the original pages should be retained.

Reference to segments that have been deleted will only appear in the Table 1 and Table 2 diagrams for this transaction beginning on page 51.

## Overall Change Summary

All N2 Additional Name Information Segments have been deleted.

A note for the code identifying Home Infusion EDI Coalition (HIEC) Procedure/Service codes was added.

The code for identifying National Drug Codes (NDC) has changed to be standard across all X12N Health Care guides.

Other requirements and notes have been changed.

Please note that changes in the addenda may have caused changes to the Data Element Dictionary and the Data Element Name Index (Appendix E in the original Implementation Guide), but are not identified in these draft addenda. Changes in the addenda may also have caused changes to the Examples and the EDI Transmission Examples (Section 4 in the original Implementation Guide), but are not identified in these draft addenda.



## IMPLEMENTATION

# 837 Health Care Claim: Professional

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.
2. This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.
3. This standard can, also, be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer's adjudication information to subsequent payers.

**Table 1 - Header**

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
61	005	ST	Transaction Set Header	R	1	
62	010	BHT	Beginning of Hierarchical Transaction	R	1	
65	015	REF	Transmission Type Identification	R	1	
LOOP ID - 1000A SUBMITTER NAME						1
66	020	NM1	Submitter Name	R	1	N2 Deleted
69	045	PER	Submitter EDI Contact Information	R	2	
LOOP ID - 1000B RECEIVER NAME						1
72	020	NM1	Receiver Name	R	1	

**Table 2 - Billing/Pay-to Provider Detail**

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL						>1
74	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	N2 Deleted
76	003	PRV	Billing/Pay-to Provider Specialty Information	S	1	
78	010	CUR	Foreign Currency Information	S	1	
LOOP ID - 2010AA BILLING PROVIDER NAME						1
81	015	NM1	Billing Provider Name	R	1	N2 Deleted
84	025	N3	Billing Provider Address	R	1	
85	030	N4	Billing Provider City/State/ZIP Code	R	1	
87	035	REF	Billing Provider Secondary Identification	S	8	
90	035	REF	Credit/Debit Card Billing Information	S	8	
92	040	PER	Billing Provider Contact Information	S	2	
LOOP ID - 2010AB PAY-TO PROVIDER NAME						1
95	015	NM1	Pay-to Provider Name	S	1	N2 Deleted
98	025	N3	Pay-to Provider Address	R	1	
99	030	N4	Pay-to Provider City/State/ZIP Code	R	1	
101	035	REF	Pay-to-Provider Secondary Identification	S	5	

**Table 2 - Subscriber Detail**

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			<b>LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL</b>			<b>&gt;1</b>
103	001	HL	Subscriber Hierarchical Level	R	1	
105	005	SBR	Subscriber Information	R	1	
109	007	PAT	Patient Information	S	1	
			<b>LOOP ID - 2010BA SUBSCRIBER NAME</b>			<b>1</b>
112	015	NM1	Subscriber Name	R	1	
115	025	N3	Subscriber Address	S	1	
116	030	N4	Subscriber City/State/ZIP Code	S	1	
118	032	DMG	Subscriber Demographic Information	S	1	
120	035	REF	Subscriber Secondary Identification	S	4	
122	035	REF	Property and Casualty Claim Number	S	1	
			<b>LOOP ID - 2010BB PAYER NAME</b>			<b>1</b>
124	015	NM1	Payer Name	R	1	
127	025	N3	Payer Address	S	1	
128	030	N4	Payer City/State/ZIP Code	S	1	
130	035	REF	Payer Secondary Identification	S	3	
			<b>LOOP ID - 2010BC RESPONSIBLE PARTY NAME</b>			<b>1</b>
132	015	NM1	Responsible Party Name	S	1	
135	025	N3	Responsible Party Address	R	1	
136	030	N4	Responsible Party City/State/ZIP Code	R	1	
			<b>LOOP ID - 2010BD CREDIT/DEBIT CARD HOLDER NAME</b>			<b>1</b>
138	015	NM1	Credit/Debit Card Holder Name	S	1	
141	035	REF	Credit/Debit Card Information	S	2	

N2 Deleted

**Table 2 - Patient Detail**

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			<b>LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL</b>			<b>&gt;1</b>
143	001	HL	Patient Hierarchical Level	S	1	
145	007	PAT	Patient Information	R	1	
			<b>LOOP ID - 2010CA PATIENT NAME</b>			<b>1</b>
148	015	NM1	Patient Name	R	1	
151	025	N3	Patient Address	R	1	
152	030	N4	Patient City/State/ZIP Code	R	1	
154	032	DMG	Patient Demographic Information	R	1	
156	035	REF	Patient Secondary Identification	S	5	
158	035	REF	Property and Casualty Claim Number	S	1	

N2 Deleted

LOOP ID - 2300 CLAIM INFORMATION					100
160	130	CLM	Claim Information	R	1
170	135	DTP	Date - Initial Treatment	S	1
172	135	DTP	Date - Date Last Seen	S	1
174	135	DTP	Date - Onset of Current Illness/Symptom	S	1
175	135	DTP	Date - Acute Manifestation	S	5
178	135	DTP	Date - Similar Illness/Symptom Onset	S	10
180	135	DTP	Date - Accident	S	10
182	135	DTP	Date - Last Menstrual Period	S	1
183	135	DTP	Date - Last X-ray	S	1
185	135	DTP	Date - Hearing and Vision Prescription Date	S	1
186	135	DTP	Date - Disability Begin	S	5
188	135	DTP	Date - Disability End	S	5
190	135	DTP	Date - Last Worked	S	1
191	135	DTP	Date - Authorized Return to Work	S	1
193	135	DTP	Date - Admission	S	1
195	135	DTP	Date - Discharge	S	1
197	135	DTP	Date - Assumed and Relinquished Care Dates	S	2
199	155	PWK	Claim Supplemental Information	S	10
202	160	CN1	Contract Information	S	1
204	175	AMT	Credit/Debit Card Maximum Amount	S	1
205	175	AMT	Patient Amount Paid	S	1
206	175	AMT	Total Purchased Service Amount	S	1
208	180	REF	Service Authorization Exception Code	S	1
210	180	REF	Mandatory Medicare (Section 4081) Crossover Indicator	S	1
212	180	REF	Mammography Certification Number	S	1
214	180	REF	Prior Authorization or Referral Number	S	2
216	180	REF	Original Reference Number (ICN/DCN)	S	1
218	180	REF	Clinical Laboratory Improvement Amendment (CLIA) Number	S	3
220	180	REF	Repriced Claim Number	S	1
222	180	REF	Adjusted Repriced Claim Number	S	1
223	180	REF	Investigational Device Exemption Number	S	1
225	180	REF	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	S	1
227	180	REF	Ambulatory Patient Group (APG)	S	4
228	180	REF	Medical Record Number	S	1
229	180	REF	Demonstration Project Identifier	S	1
231	185	K3	File Information	S	10
233	190	NTE	Claim Note	S	1
235	195	CR1	Ambulance Transport Information	S	1
238	200	CR2	Spinal Manipulation Service Information	S	1
241	220	CRC	Ambulance Certification	S	3
246	220	CRC	Patient Condition Information: Vision	S	3
249	220	CRC	Homebound Indicator	S	1
251	220	CRC	EPSDT Referral	S	1
254	231	HI	Health Care Diagnosis Code	S	1
260	241	HCP	Claim Pricing/Repricing Information	S	1
LOOP ID - 2305 HOME HEALTH CARE PLAN INFORMATION					6
265	242	CR7	Home Health Care Plan Information	S	1
267	243	HSD	Health Care Services Delivery	S	3
LOOP ID - 2310A REFERRING PROVIDER NAME					2
271	250	NM1	Referring Provider Name	S	1
274	255	PRV	Referring Provider Specialty Information	S	1

DTP  
Deleted

New  
Segment  
Added

N2 Deleted

276	271	REF	Referring Provider Secondary Identification	S	5	
<b>LOOP ID - 2310B RENDERING PROVIDER NAME</b>						<b>1</b>
278	250	NM1	Rendering Provider Name	S	1	Usage
281	255	PRV	Rendering Provider Specialty Information	S	1	Changed
283	271	REF	Rendering Provider Secondary Identification	S	5	N2 Deleted
<b>LOOP ID - 2310C PURCHASED SERVICE PROVIDER NAME</b>						<b>1</b>
285	250	NM1	Purchased Service Provider Name	S	1	
288	271	REF	Purchased Service Provider Secondary Identification	S	5	
<b>LOOP ID - 2310D SERVICE FACILITY LOCATION</b>						<b>1</b>
290	250	NM1	Service Facility Location	S	1	N2 Deleted
293	265	N3	Service Facility Location Address	R	1	
294	270	N4	Service Facility Location City/State/ZIP	R	1	
296	271	REF	Service Facility Location Secondary Identification	S	5	
<b>LOOP ID - 2310E SUPERVISING PROVIDER NAME</b>						<b>1</b>
298	250	NM1	Supervising Provider Name	S	1	N2 Deleted
301	271	REF	Supervising Provider Secondary Identification	S	5	
<b>LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION</b>						<b>10</b>
303	290	SBR	Other Subscriber Information	S	1	
308	295	CAS	Claim Level Adjustments	S	5	
317	300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1	
318	300	AMT	Coordination of Benefits (COB) Approved Amount	S	1	
319	300	AMT	Coordination of Benefits (COB) Allowed Amount	S	1	
320	300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	S	1	
321	300	AMT	Coordination of Benefits (COB) Covered Amount	S	1	
322	300	AMT	Coordination of Benefits (COB) Discount Amount	S	1	
323	300	AMT	Coordination of Benefits (COB) Per Day Limit Amount	S	1	
324	300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	1	
325	300	AMT	Coordination of Benefits (COB) Tax Amount	S	1	
326	300	AMT	Coordination of Benefits (COB) Total Claim Before Taxes Amount	S	1	
327	305	DMG	Subscriber Demographic Information	S	1	
329	310	OI	Other Insurance Coverage Information	R	1	
332	320	MOA	Medicare Outpatient Adjudication Information	S	1	
<b>LOOP ID - 2330A OTHER SUBSCRIBER NAME</b>						<b>1</b>
335	325	NM1	Other Subscriber Name	R	1	N2 Deleted
338	332	N3	Other Subscriber Address	S	1	
339	340	N4	Other Subscriber City/State/ZIP Code	S	1	
341	355	REF	Other Subscriber Secondary Identification	S	3	
<b>LOOP ID - 2330B OTHER PAYER NAME</b>						<b>1</b>
343	325	NM1	Other Payer Name	R	1	N2 Deleted
346	345	PER	Other Payer Contact Information	S	2	
349	345	DTP	Claim Adjudication Date	S	1	
351	355	REF	Other Payer Secondary Identifier	S	2	
353	355	REF	Other Payer Prior Authorization or Referral Number	S	2	
355	355	REF	Other Payer Claim Adjustment Indicator	S	2	
<b>LOOP ID - 2330C OTHER PAYER PATIENT INFORMATION</b>						<b>1</b>
357	325	NM1	Other Payer Patient Information	S	1	
359	355	REF	Other Payer Patient Identification	S	3	
<b>LOOP ID - 2330D OTHER PAYER REFERRING PROVIDER</b>						<b>2</b>
361	325	NM1	Other Payer Referring Provider	S	1	

363	355	REF	Other Payer Referring Provider Identification	R	3	
			<b>LOOP ID - 2330E OTHER PAYER RENDERING PROVIDER</b>		<b>1</b>	
365	325	NM1	Other Payer Rendering Provider	S	1	
367	355	REF	Other Payer Rendering Provider Secondary Identification	R	3	
			<b>LOOP ID - 2330F OTHER PAYER PURCHASED SERVICE PROVIDER</b>		<b>1</b>	
369	325	NM1	Other Payer Purchased Service Provider	S	1	
371	355	REF	Other Payer Purchased Service Provider Identification	R	3	
			<b>LOOP ID - 2330G OTHER PAYER SERVICE FACILITY LOCATION</b>		<b>1</b>	
373	325	NM1	Other Payer Service Facility Location	S	1	
375	355	REF	Other Payer Service Facility Location Identification	R	3	
			<b>LOOP ID - 2330H OTHER PAYER SUPERVISING PROVIDER</b>		<b>1</b>	
377	325	NM1	Other Payer Supervising Provider	S	1	
379	355	REF	Other Payer Supervising Provider Identification	R	3	
			<b>LOOP ID - 2400 SERVICE LINE</b>		<b>50</b>	
381	365	LX	Service Line	R	1	
383	370	SV1	Professional Service	R	1	
391	400	SV5	Durable Medical Equipment Service	S	1	SV4 Deleted SV5 Added
394	420	PWK	DMERC CMN Indicator	S	1	
396	425	CR1	Ambulance Transport Information	S	1	
399	430	CR2	Spinal Manipulation Service Information	S	5	
402	435	CR3	Durable Medical Equipment Certification	S	1	
404	445	CR5	Home Oxygen Therapy Information	S	1	
408	450	CRC	Ambulance Certification	S	3	
411	450	CRC	Hospice Employee Indicator	S	1	
413	450	CRC	DMERC Condition Indicator	S	2	
416	455	DTP	Date - Service Date	R	1	
418	455	DTP	Date - Certification Revision Date	S	1	
420	455	DTP	Date - Begin Therapy Date	S	1	DTP Deleted
422	455	DTP	Date - Last Certification Date	S	1	
424	455	DTP	Date - Date Last Seen	S	1	
426	455	DTP	Date - Test	S	2	
428	455	DTP	Date - Oxygen Saturation/Arterial Blood Gas Test	S	3	
430	455	DTP	Date - Shipped	S	1	
431	455	DTP	Date - Onset of Current Symptom/Illness	S	1	
433	455	DTP	Date - Last X-ray	S	1	
435	455	DTP	Date - Acute Manifestation	S	1	
437	455	DTP	Date - Initial Treatment	S	1	
439	455	DTP	Date - Similar Illness/Symptom Onset	S	1	
441	462	MEA	Test Result	S	20	QTY Deleted
444	465	CN1	Contract Information	S	1	
446	470	REF	Repriced Line Item Reference Number	S	1	
447	470	REF	Adjusted Repriced Line Item Reference Number	S	1	
448	470	REF	Prior Authorization or Referral Number	S	2	
450	470	REF	Line Item Control Number	S	1	
452	470	REF	Mammography Certification Number	S	1	
454	470	REF	Clinical Laboratory Improvement Amendment (CLIA) Identification	S	1	
456	470	REF	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification	S	1	
457	470	REF	Immunization Batch Number	S	1	
458	470	REF	Ambulatory Patient Group (APG)	S	4	
459	470	REF	Oxygen Flow Rate	S	1	

461	470	REF	Universal Product Number (UPN)	S	1	
463	475	AMT	Sales Tax Amount	S	1	
464	475	AMT	Approved Amount	S	1	
465	475	AMT	Postage Claimed Amount	S	1	
466	480	K3	File Information	S	10	
467	485	NTE	Line Note	S	1	
468	488	PS1	Purchased Service Information	S	1	
470	491	HSD	Health Care Services Delivery	S	1	
474	492	HCP	Line Pricing/Repricing Information	S	1	
<b>LOOP ID - 2410 DRUG IDENTIFICATION</b>					<b>25</b>	
480	494	LIN	Drug Identification	S	1	
483	495	CTP	Drug Pricing	S	1	
486	496	REF	Prescription Number	S	1	
<b>LOOP ID - 2420A RENDERING PROVIDER NAME</b>					<b>1</b>	
488	500	NM1	Rendering Provider Name	S	1	Usage
491	505	PRV	Rendering Provider Specialty Information	S	1	Changed
493	525	REF	Rendering Provider Secondary Identification	S	5	N2 Deleted
<b>LOOP ID - 2420B PURCHASED SERVICE PROVIDER NAME</b>					<b>1</b>	
495	500	NM1	Purchased Service Provider Name	S	1	
498	525	REF	Purchased Service Provider Secondary Identification	S	5	
<b>LOOP ID - 2420C SERVICE FACILITY LOCATION</b>					<b>1</b>	
500	500	NM1	Service Facility Location	S	1	N2 Deleted
503	514	N3	Service Facility Location Address	R	1	
504	520	N4	Service Facility Location City/State/ZIP	R	1	
506	525	REF	Service Facility Location Secondary Identification	S	5	
<b>LOOP ID - 2420D SUPERVISING PROVIDER NAME</b>					<b>1</b>	
508	500	NM1	Supervising Provider Name	S	1	N2 Deleted
511	525	REF	Supervising Provider Secondary Identification	S	5	
<b>LOOP ID - 2420E ORDERING PROVIDER NAME</b>					<b>1</b>	
513	500	NM1	Ordering Provider Name	S	1	N2 Deleted
516	514	N3	Ordering Provider Address	S	1	
517	520	N4	Ordering Provider City/State/ZIP Code	S	1	
519	525	REF	Ordering Provider Secondary Identification	S	5	
521	530	PER	Ordering Provider Contact Information	S	1	
<b>LOOP ID - 2420F REFERRING PROVIDER NAME</b>					<b>2</b>	
524	500	NM1	Referring Provider Name	S	1	
527	505	PRV	Referring Provider Specialty Information	S	1	N2 Deleted
529	525	REF	Referring Provider Secondary Identification	S	5	
<b>LOOP ID - 2420G OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER</b>					<b>4</b>	
531	500	NM1	Other Payer Prior Authorization or Referral Number	S	1	
534	525	REF	Other Payer Prior Authorization or Referral Number	R	2	
<b>LOOP ID - 2430 LINE ADJUDICATION INFORMATION</b>					<b>25</b>	
536	540	SVD	Line Adjudication Information	S	1	
540	545	CAS	Line Adjustment	S	99	
548	550	DTP	Line Adjudication Date	R	1	
<b>LOOP ID - 2440 FORM IDENTIFICATION CODE</b>					<b>5</b>	
549	551	LQ	Form Identification Code	S	1	
551	552	FRM	Supporting Documentation	R	99	
554	555	SE	Transaction Set Trailer	R	1	

## IMPLEMENTATION

## TRANSMISSION TYPE IDENTIFICATION

Usage: REQUIRED

Repeat: 1

Example: REF\*87\*004010X098D~

## STANDARD

## REF Reference Identification

Level: Header

Position: 015

Loop: \_\_\_\_\_

Requirement: Optional

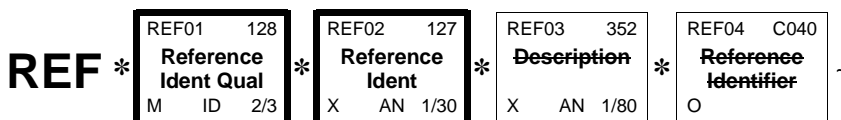
Max Use: 3

Purpose: To specify identifying information

Syntax: 1. R0203

At least one of REF02 or REF03 is required.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M	ID	2/3				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>87</td><td><b>Functional Category</b></td></tr></table>							CODE	DEFINITION	87	<b>Functional Category</b>
CODE	DEFINITION									
87	<b>Functional Category</b>									
REQUIRED	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  <i>INDUSTRY: <b>Transmission Type Code</b></i>  SYNTAX: R0203  <div><div>Note Changed</div><div>When piloting the transaction set, this value is 004010X098DA1. When sending the transaction set in a production mode, this value is 004010X098A1.</div></div>	X	AN	1/30				
NOT USED	REF03	352	<b>Description</b>	X	AN	1/80				
NOT USED	REF04	C040	<b>REFERENCE IDENTIFIER</b>	O						

## IMPLEMENTATION

BILLING/PAY-TO PROVIDER SPECIALTY  
INFORMATION

Loop: 2000A — BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when adjudication is known to be impacted by the provider taxonomy code, and the Rendering Provider is the same entity as the Billing and/or Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.

Note 1. Changed

2. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.

3. PRV02 qualifies PRV03.

Example: PRV\*BI\*ZZ\*203BA050N~

## STANDARD

## PRV Provider Information

Level: Detail

Position: 003

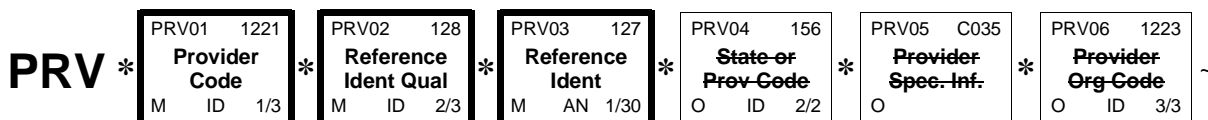
Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	<b>Provider Code</b> Code identifying the type of provider	M ID 1/3
			CODE	DEFINITION
			BI	Billing
			PT	Pay-To

SITUATIONAL	PAT05	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format  SYNTAX: P0506	X	ID	2/3
Note Changed			Required if patient is known to be deceased and the date of death is available to the provider billing system.			
			CODE	DEFINITION		
			D8	Date Expressed in Format CCYYMMDD		
SITUATIONAL	PAT06	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times  INDUSTRY: Insured Individual Death Date  ALIAS: Date of Death  SYNTAX: P0506  SEMANTIC: PAT06 is the date of death.  NSF Reference: CA0-21.0	X	AN	1/35
Note Changed			Required if patient is known to be deceased and the date of death is available to the provider billing system.			
SITUATIONAL	PAT07	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken  SYNTAX: P0708	X	ID	2/2
Note Changed			Required when PAT08 is used.			
Code 01 Added Code GR Deleted			CODE	DEFINITION		
			01	Actual Pounds		
SITUATIONAL	PAT08	81	Weight Numeric value of weight  INDUSTRY: Patient Weight  SYNTAX: P0708  SEMANTIC: PAT08 is the patient's weight.  NSF Reference: FA0-44.0, GU0-17.0	X	R	1/10
Note Changed			Required on: 1) claims/encounters involving EPO (epoetin) for patients on dialysis. 2) Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02.			

<b>SITUATIONAL</b>	<b>PAT09</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>	<b>O</b>	<b>ID</b>	<b>1/1</b>
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Code indicating a Yes or No condition or response

**INDUSTRY: Pregnancy Indicator**

**SEMANTIC:** PAT09 indicates whether the patient is pregnant or not pregnant. Code "Y" indicates the patient is pregnant; code "N" indicates the patient is not pregnant.

Note Changed

**Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable law. The "Y" code indicates that the patient is pregnant. If PAT09 is not used it means the patient is not pregnant.**

Code N Added

CODE	DEFINITION
N	No
Y	Yes

<b>SITUATIONAL</b>	<b>NM108</b>	<b>66</b>	<b>Identification Code Qualifier</b>	<b>X</b>	<b>ID</b>	<b>1/2</b>
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Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

**Required if NM102 = 1 (person)**

CODE	DEFINITION
<b>MI</b>	<p><b>Member Identification Number</b></p> <p>The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.</p> <p>MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State).</p> <p>In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in REF02.</p>
<b>ZZ</b>	<p><b>Mutually Defined</b></p> <p>The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.</p>

<b>SITUATIONAL</b>	<b>NM109</b>	<b>67</b>	<b>Identification Code</b>	<b>X</b>	<b>AN</b>	<b>2/80</b>
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Code identifying a party or other code

*INDUSTRY: Subscriber Primary Identifier*

SYNTAX: P0809

**NSF Reference:**

**DA0-18.0, CA1-05.0, CA1-06.0**

Note Changed

Required if the Subscriber is the patient. If the subscriber is not the patient, use if known. An identifier must be present in either the subscriber or the patient loop.

<b>NOT USED</b>	<b>NM110</b>	<b>706</b>	<b>Entity Relationship Code</b>	<b>X</b>	<b>ID</b>	<b>2/2</b>
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<b>NOT USED</b>	<b>NM111</b>	<b>98</b>	<b>Entity Identifier Code</b>	<b>O</b>	<b>ID</b>	<b>2/3</b>
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IMPLEMENTATION

## PROPERTY AND CASUALTY CLAIM NUMBER

Loop: 2010BA — SUBSCRIBER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place.

2. This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 4.2, Property and Casualty, for additional information about property and casualty claims.

New Note Added — 3. Not required for HIPAA (The statutory definition of a health plan does not specifically include workers' compensation programs, property and casualty programs, or disability insurance programs, and, consequently, we are not requiring them to comply with the standards.) but may be required for other uses.

Example: REF\*Y4\*4445555~

STANDARD

### REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

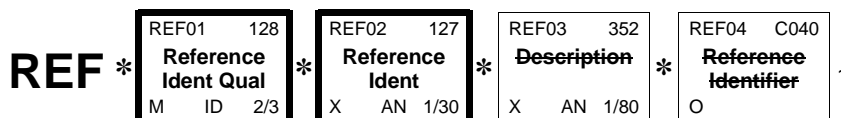
Max Use: 20

Purpose: To specify identifying information

Syntax: 1. R0203

At least one of REF02 or REF03 is required.

DIAGRAM



05	Grandson or Granddaughter
07	Nephew or Niece
09	Adopted Child
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
34	Other Adult
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
G8	Other Relationship

NOT USED	PAT02	1384	Patient Location Code	O	ID	1/1
NOT USED	PAT03	584	Employment Status Code	O	ID	2/2
NOT USED	PAT04	1220	Student Status Code	O	ID	1/1
SITUATIONAL	PAT05	1250	Date Time Period Format Qualifier	X	ID	2/3

Code indicating the date format, time format, or date and time format

SYNTAX: P0506

**Note Changed** — Required if patient is known to be deceased and the date of death is available to the provider billing system.

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD

SITUATIONAL	PAT06	1251	<b>Date Time Period</b>	X	AN	1/35
			Expression of a date, a time, or range of dates, times or dates and times			
			INDUSTRY: <i>Patient Death Date</i>			
			ALIAS: <i>Date of Death</i>			
			SYNTAX: P0506			
			SEMANTIC: PAT06 is the date of death.			
			NSF Reference:			
			CA0-21.0			
Note Changed			Required if patient is known to be deceased and the date of death is available to the provider billing system.			
SITUATIONAL	PAT07	355	<b>Unit or Basis for Measurement Code</b>	X	ID	2/2
			Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken			
			SYNTAX: P0708			
Note Changed			Required when PAT08 is used.			
Code 01 Added Code GR Deleted			CODE	DEFINITION		
			01	Actual Pounds		
SITUATIONAL	PAT08	81	<b>Weight</b>	X	R	1/10
			Numeric value of weight			
			INDUSTRY: <i>Patient Weight</i>			
			SYNTAX: P0708			
			SEMANTIC: PAT08 is the patient's weight.			
			NSF Reference:			
			FA0-44.0, GU0-17.0			
Note Changed			Required on: 1) claims/encounters involving EPO (epoetin) for patients on dialysis. 2) Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02.			
SITUATIONAL	PAT09	1073	<b>Yes/No Condition or Response Code</b>	O	ID	1/1
			Code indicating a Yes or No condition or response			
			INDUSTRY: <i>Pregnancy Indicator</i>			
			SEMANTIC: PAT09 indicates whether the patient is pregnant or not pregnant. Code "Y" indicates the patient is pregnant; code "N" indicates the patient is not pregnant.			
Note Changed			Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable law. The "Y" code indicates that the patient is pregnant. If PAT09 is not used it means the patient is not pregnant.			
Code N Added			CODE	DEFINITION		
			N	No		
			Y	Yes		

IMPLEMENTATION

## PROPERTY AND CASUALTY CLAIM NUMBER

Loop: 2010CA — PATIENT NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place.

2. This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 4.2, Property and Casualty, for additional information about property and casualty claims.

New Note Added — 3. Not required for HIPAA (The statutory definition of a health plan does not specifically include workers' compensation programs, property and casualty programs, or disability insurance programs, and, consequently, we are not requiring them to comply with the standards.) but may be required for other uses.

Example: REF\*Y4\*4445555~

STANDARD

### REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

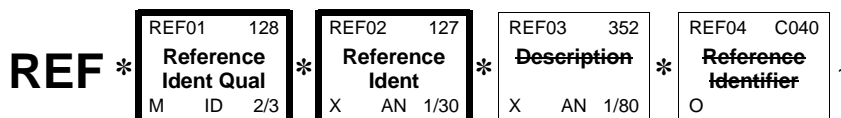
Max Use: 20

Purpose: To specify identifying information

Syntax: 1. R0203

At least one of REF02 or REF03 is required.

DIAGRAM



**REQUIRED** CLM05 - 3 1325 **Claim Frequency Type Code** O ID 1/1  
Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

*INDUSTRY: Claim Frequency Code*

*ALIAS: Claim Submission Reason Code*

CODE SOURCE 235: Claim Frequency Type Code

Note and Codes Deleted

**REQUIRED** CLM06 1073 **Yes/No Condition or Response Code** O ID 1/1  
Code indicating a Yes or No condition or response

*INDUSTRY: Provider or Supplier Signature Indicator*

*ALIAS: Provider Signature on File*

**SEMANTIC:** CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.

**NSF Reference:**

EA0-37.0

CODE	DEFINITION
N	No
Y	Yes

**REQUIRED** CLM07 1359 **Provider Accept Assignment Code** O ID 1/1  
Code indicating whether the provider accepts assignment

*INDUSTRY: Medicare Assignment Code*

**NSF Reference:**

EA0-36.0, FA0-59.0

CLM07 indicates whether the provider accepts Medicare assignment.

The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations.

CODE	DEFINITION
A	Assigned
B	Assignment Accepted on Clinical Lab Services Only
C	Not Assigned
P	Patient Refuses to Assign Benefits

**SITUATIONAL**      **CLM10**      **1351**      **Patient Signature Source Code**      **O**      **ID**      **1/1**

Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider

*ALIAS: Patient Signature Source Code***NSF Reference:****DA0-16.0****CLM10 is required except in cases where code “N” is used in CLM09.**

CODE	DEFINITION
B	Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file
C	Signed HCFA-1500 Claim Form on file
M	Signed signature authorization form for HCFA-1500 Claim Form block 13 on file
P	Signature generated by provider because the patient was not physically present for services
S	Signed signature authorization form for HCFA-1500 Claim Form block 12 on file

**SITUATIONAL**      **CLM11**      **C024**      **RELATED CAUSES INFORMATION**      **O**  
To identify one or more related causes and associated state or country information*ALIAS: Accident/Employment/Related Causes***CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0.****If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.****REQUIRED**      **CLM11 - 1**      **1362**      **Related-Causes Code**      **M**      **ID**      **2/3**  
Code identifying an accompanying cause of an illness, injury or an accident*INDUSTRY: Related Causes Code***NSF Reference:****EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator**

CODE	DEFINITION
AA	Auto Accident
AP	Another Party Responsible
EM	Employment
OA	Other Accident

Code AB Deleted

**SITUATIONAL** CLM11 - 2 1362 **Related-Causes Code** O ID 2/3

Code identifying an accompanying cause of an illness, injury or an accident

*INDUSTRY: Related Causes Code***NSF Reference:**

EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator

Used if more than one code applies.

Code AB Deleted

CODE	DEFINITION
AA	Auto Accident
AP	Another Party Responsible
EM	Employment
OA	Other Accident

**SITUATIONAL** CLM11 - 3 1362 **Related-Causes Code** O ID 2/3

Code identifying an accompanying cause of an illness, injury or an accident

*INDUSTRY: Related Causes Code***NSF Reference:**

EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator

Used if more than one code applies.

Code AB Deleted

CODE	DEFINITION
AA	Auto Accident
AP	Another Party Responsible
EM	Employment
OA	Other Accident

**SITUATIONAL** CLM11 - 4 156 **State or Province Code** O ID 2/2

Code (Standard State/Province) as defined by appropriate government agency

*INDUSTRY: Auto Accident State or Province Code*

CODE SOURCE 22: States and Outlying Areas of the U.S.

**NSF Reference:**

EA0-10.0

Required if CLM11-1, -2, or -3 = AA to identify the state in which the automobile accident occurred. Use state postal code (CA = California, UT = Utah, etc).

<b>SITUATIONAL</b>	<b>CLM11 - 5</b>	<b>26</b>	<b>Country Code</b>	<b>O</b>	<b>ID</b>	<b>2/3</b>
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Code identifying the country

CODE SOURCE 5: Countries, Currencies and Funds

**Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred.**

<b>SITUATIONAL</b>	<b>CLM12</b>	<b>1366</b>	<b>Special Program Code</b>	<b>O</b>	<b>ID</b>	<b>2/3</b>
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Code indicating the Special Program under which the services rendered to the patient were performed

INDUSTRY: *Special Program Indicator*ALIAS: *Special Program Code*

NSF Reference:

EA0-43.0

**Required if the services were rendered under one of the following circumstances/programs/projects.**

CODE	DEFINITION
01	Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)
02	Physically Handicapped Children's Program
03	Special Federal Funding This code is used for Medicaid claims only.
05	Disability This code is used for Medicaid claims only.
07	Induced Abortion - Danger to Life This code is used for Medicaid claims only.
08	Induced Abortion - Rape or Incest This code is used for Medicaid claims only.
09	Second Opinion or Surgery This code is used for Medicaid claims only.

Note Added

<b>NOT USED</b>	<b>CLM13</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>	<b>O</b>	<b>ID</b>	<b>1/1</b>
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<b>NOT USED</b>	<b>CLM14</b>	<b>1338</b>	<b>Level of Service Code</b>	<b>O</b>	<b>ID</b>	<b>1/3</b>
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<b>NOT USED</b>	<b>CLM15</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>	<b>O</b>	<b>ID</b>	<b>1/1</b>
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## IMPLEMENTATION

## DATE - DATE LAST SEEN

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Note 1. Changed **Notes:** 1. Required when Medicare Part B claims involve services from an independent physical therapist, occupational therapist, or physician services involving routine foot care.

2. This is the date that the patient was seen by the attending/supervising physician for the qualifying medical condition related to the services performed.

Example: DTP\*304\*D8\*19970115~

## STANDARD

## DTP Date or Time or Period

Level: Detail

Position: 135

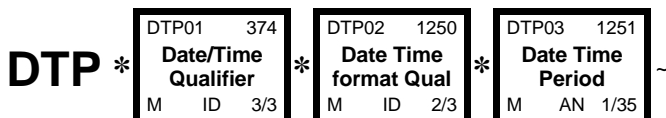
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <i>INDUSTRY: <b>Date Time Qualifier</b></i>	M	ID	3/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>304</td><td><b>Latest Visit or Consultation</b></td></tr></table>	CODE	DEFINITION	304	<b>Latest Visit or Consultation</b>			
CODE	DEFINITION									
304	<b>Latest Visit or Consultation</b>									
REQUIRED	DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <b>SEMANTIC:</b> DTP02 is the date or time or period format that will appear in DTP03.	M	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>D8</td><td><b>Date Expressed in Format CCYYMMDD</b></td></tr></table>	CODE	DEFINITION	D8	<b>Date Expressed in Format CCYYMMDD</b>			
CODE	DEFINITION									
D8	<b>Date Expressed in Format CCYYMMDD</b>									

IMPLEMENTATION

## DATE - DISABILITY BEGIN

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 5

Notes: 1. Required on claims involving disability where, in the opinion of the provider, the patient was or will be unable to perform the duties normally associated with his/her work.

New Note 2. Added — 2. Not required for HIPAA but may be required for other uses. (The statutory definition of a health plan does not specifically include workers compensation programs, property and casualty programs, or disability insurance programs.)

Example: DTP\*360\*D8\*19970114~

STANDARD

### DTP Date or Time or Period

Level: Detail

Position: 135

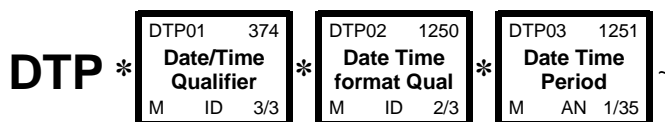
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <i>INDUSTRY: Date Time Qualifier</i>	M ID 3/3
			CODE	DEFINITION
		360	<b>Disability Begin</b>	
REQUIRED	DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <i>SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.</i>	M ID 2/3
			CODE	DEFINITION
		D8	<b>Date Expressed in Format CCYYMMDD</b>	

## IMPLEMENTATION

## DATE - DISABILITY END

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 5

Notes: 1. Required on claims/encounters involving disability where, in the opinion of the provider, the patient, after having been absent from work for reasons related to the disability, was or will be able to perform the duties normally associated with his/her work.

New Note 2. Added — 2. Not required for HIPAA but may be required for other uses. (The statutory definition of a health plan does not specifically include workers compensation programs, property and casualty programs, or disability insurance programs.)

Example: DTP\*361\*D8\*19970613~

## STANDARD

## DTP Date or Time or Period

Level: Detail

Position: 135

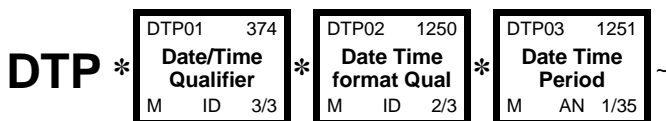
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <i>INDUSTRY: Date Time Qualifier</i>	M	ID	3/3
			CODE	DEFINITION		
			361	Disability End		

## IMPLEMENTATION

## PATIENT AMOUNT PAID

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when patient has made payment specifically toward this claim.

Note Changed

2. Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s).

Note 3. Deleted

Example: AMT\*F5\*152.45~

## STANDARD

**AMT** Monetary Amount

Level: Detail

Position: 175

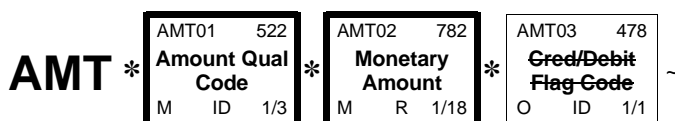
Loop: 2300

Requirement: Optional

Max Use: 40

Purpose: To indicate the total monetary amount

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M	ID	1/3
			CODE	DEFINITION		
			F5	Patient Amount Paid		
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M	R	1/18
			INDUSTRY: Patient Amount Paid			
			NSF Reference:			
			XA0-19.0			
NOT USED	AMT03	478	Credit/Debit Flag Code	O	ID	1/1

## IMPLEMENTATION

## TOTAL PURCHASED SERVICE AMOUNT

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required if there are purchased service components to this claim.

- New Note Added
- 2. Use this segment on vision claims when the acquisition cost of lenses is known to impact adjudication or reimbursement.
  - 3. Required on service lines when the purchased service charge amount is necessary for processing.

Example: AMT\*NE\*57.35~

## STANDARD

## AMT Monetary Amount

Level: Detail

Position: 175

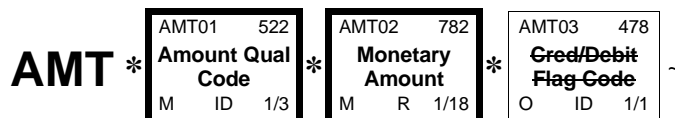
Loop: 2300

Requirement: Optional

Max Use: 40

Purpose: To indicate the total monetary amount

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3
			CODE DEFINITION	
			NE Net Billed Use this code to indicate Total Purchased Service Charges.	
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M R 1/18
			INDUSTRY: Total Purchased Service Amount	
			NSF Reference:	
			EA0-31.0	

## IMPLEMENTATION

## MAMMOGRAPHY CERTIFICATION NUMBER

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Note Changed — Notes: 1. Required when mammography services are rendered by a certified mammography provider.

Example: REF\*EW\*T554~

## STANDARD

## REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

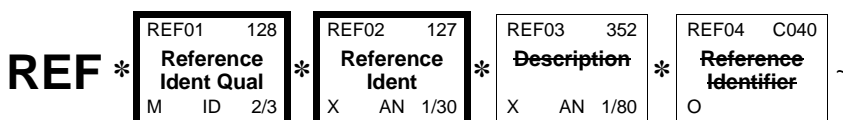
Max Use: 30

Purpose: To specify identifying information

Syntax: 1. R0203

At least one of REF02 or REF03 is required.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3
			CODE	DEFINITION
			EW	Mammography Certification Number
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  INDUSTRY: Mammography Certification Number  SYNTAX: R0203  NSF Reference: FA0-31.0	X AN 1/30
NOT USED	REF03	352	Description	X AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

## IMPLEMENTATION

SPINAL MANIPULATION SERVICE  
INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. The CR2 segment in Loop ID-2300 applies to the entire claim unless overridden by the presence of a CR2 segment in Loop ID-2400.

Note 2. Changed — 2. Required on all Medicare Part B chiropractic claims involving spinal manipulation.

Example: CR2\*\*\*\*\*M\*\*\*Y~ — Example Changed

## STANDARD

## CR2 Chiropractic Certification

Level: Detail

Position: 200

Loop: 2300

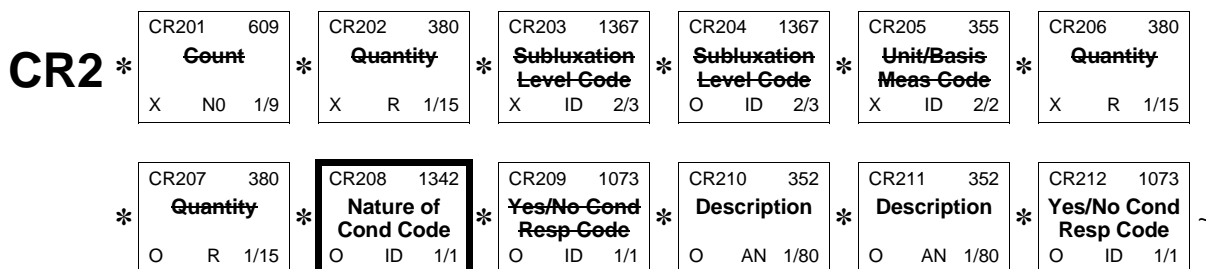
Requirement: Optional

Max Use: 1

Purpose: To supply information related to the chiropractic service rendered to a patient

- Syntax: 1. **P0102**  
If either CR201 or CR202 is present, then the other is required.
2. **C0403**  
If CR204 is present, then CR203 is required.
3. **P0506**  
If either CR205 or CR206 is present, then the other is required.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	CR201	609	Count	X NO 1/9
NOT USED	CR202	380	Quantity	X R 1/15

Usage Changed

NOT USED	CR203	1367	Subluxation Level Code	X	ID	2/3
NOT USED	CR204	1367	Subluxation Level Code	O	ID	2/3
NOT USED	CR205	355	Unit or Basis for Measurement Code	X	ID	2/2
NOT USED	CR206	380	Quantity	X	R	1/15
NOT USED	CR207	380	Quantity	O	R	1/15
REQUIRED	CR208	1342	Nature of Condition Code Code indicating the nature of a patient's condition	O	ID	1/1

*INDUSTRY: Patient Condition Code***Usage Changed** *ALIAS: Nature of Condition Code. Spinal Manipulation***NSF Reference:****GC0-11.0**

CODE	DEFINITION
A	Acute Condition
C	Chronic Condition
D	Non-acute
E	Non-Life Threatening
F	Routine
G	Symptomatic
M	Acute Manifestation of a Chronic Condition

NOT USED	CR209	1073	Yes/No Condition or Response Code	O	ID	1/1
SITUATIONAL	CR210	352	Description A free-form description to clarify the related data elements and their content	O	AN	1/80

*INDUSTRY: Patient Condition Description**ALIAS: Patient Condition Description. Spinal Manipulation*

SEMANTIC: CR210 is a description of the patient's condition.

**NSF Reference:****GC0-14.0****Used at discretion of submitter.**

SITUATIONAL	CR211	352	Description A free-form description to clarify the related data elements and their content	O	AN	1/80
-------------	-------	-----	---	---	----	------

*INDUSTRY: Patient Condition Description**ALIAS: Patient Condition Description. Spinal Manipulation*

SEMANTIC: CR211 is an additional description of the patient's condition.

**NSF Reference:****GC0-14.0****Used at discretion of submitter.**

**SITUATIONAL** CR212 1073 **Yes/No Condition or Response Code** O ID 1/1

Code indicating a Yes or No condition or response

Usage Changed

**INDUSTRY:** *X-ray Availability Indicator*

**ALIAS:** *X-ray Availability Indicator. Spinal Manipulation*

**SEMANTIC:** CR212 is X-rays availability indicator. A "Y" value indicates X-rays are maintained and available for carrier review; an "N" value indicates X-rays are not maintained and available for carrier review.

**NSF Reference:**

**GC0-15.0**

New Note Added

**Required for service dates prior to January 1, 2000.**

CODE	DEFINITION
N	No
Y	Yes

## IMPLEMENTATION

## PATIENT CONDITION INFORMATION: VISION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 3

Note Changed — Notes: 1. Required on vision claims/encounters involving replacement lenses or frames when this information is known to impact reimbursement.

Example: CRC\*E1\*Y\*L1~

## STANDARD

## CRC Conditions Indicator

Level: Detail

Position: 220

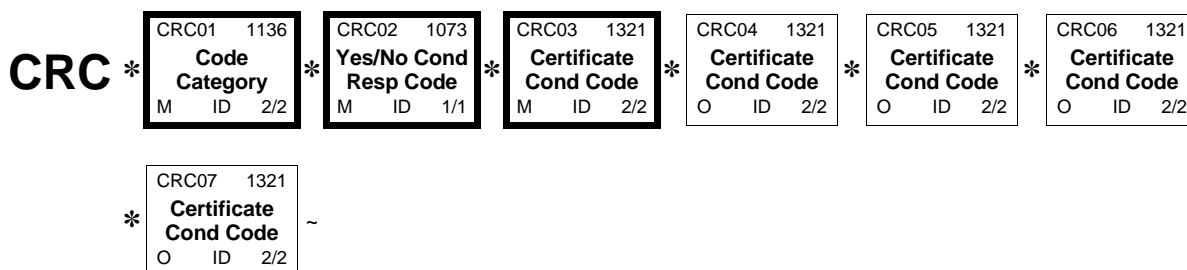
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES										
REQUIRED	CRC01	1136	<b>Code Category</b> Specifies the situation or category to which the code applies  SEMANTIC: CRC01 qualifies CRC03 through CRC07.	M	ID	2/2								
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>E1</td><td>Spectacle Lenses</td></tr><tr><td>E2</td><td>Contact Lenses</td></tr><tr><td>E3</td><td>Spectacle Frames</td></tr></table>	CODE	DEFINITION	E1	Spectacle Lenses	E2	Contact Lenses	E3	Spectacle Frames			
CODE	DEFINITION													
E1	Spectacle Lenses													
E2	Contact Lenses													
E3	Spectacle Frames													

## IMPLEMENTATION

## EPSDT REFERRAL

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required on EPSDT claims/encounters.

Example: CRC\*ZZ\*Y\*ST~

## STANDARD

## CRC Conditions Indicator

Level: Detail

Position: 220

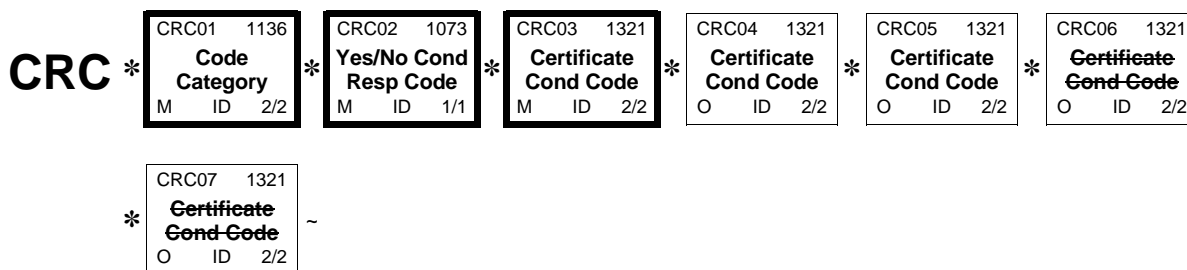
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	CRC01	1136	<b>Code Category</b> Specifies the situation or category to which the code applies SEMANTIC: CRC01 qualifies CRC03 through CRC07.	M ID 2/2
			CODE	DEFINITION
			ZZ	<b>Mutually Defined</b> EPSDT Screening referral information.

REQUIRED	CRC02	1073	Yes/No Condition or Response Code	M	ID	1/1
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Code indicating a Yes or No condition or response

*INDUSTRY: Certification Condition Indicator**ALIAS: Certification Condition Code Applies Indicator*

**SEMANTIC:** CRC02 is a Certification Condition Code applies indicator. A “Y” value indicates the condition codes in CRC03 through CRC07 apply; an “N” value indicates the condition codes in CRC03 through CRC07 do not apply.

**Was an EPSDT referral given to the patient?**

CODE	DEFINITION
N	No If no, then choose “NU” in CRC03 indicating no referral given.
Y	Yes

REQUIRED	CRC03	1321	Condition Indicator	M	ID	2/2
----------	-------	------	---------------------	---	----	-----

Code indicating a condition

*INDUSTRY: Condition Code**ALIAS: Condition Indicator***The codes for CRC03 also can be used for CRC04 through CRC07.**

CODE	DEFINITION
AV	Available - Not Used Patient refused referral.
NU	Not Used This conditioner indicator must be used when the submitter answers “N” in CRC02.
S2	Under Treatment Patient is currently under treatment for referred diagnostic or corrective health problem.
ST	New Services Requested Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).

SITUATIONAL	CRC04	1321	Condition Indicator	O	ID	2/2
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Code indicating a condition

*INDUSTRY: Condition Code***Use codes listed in CRC03.****Required if additional condition codes are needed.**

SITUATIONAL	CRC05	1321	Condition Indicator Code indicating a condition	O	ID	2/2
			<i>INDUSTRY: Condition Code</i>			
			Use codes listed in CRC03.			
			Required if additional condition codes are needed.			
NOT USED	CRC06	1321	Condition Indicator	O	ID	2/2
NOT USED	CRC07	1321	Condition Indicator	O	ID	2/2

## IMPLEMENTATION

REFERRING PROVIDER SPECIALTY  
INFORMATION

Loop: 2310A — REFERRING PROVIDER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.

Note 2. Changed — 2. Required when adjudication is known to be impacted by provider taxonomy code.

3. PRV02 qualifies PRV03.

Example: PRV\*RF\*ZZ\*363LP0200N~

## STANDARD

## PRV Provider Information

Level: Detail

Position: 255

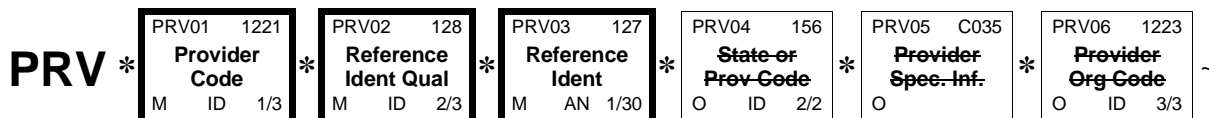
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	Provider Code Code identifying the type of provider	M ID 1/3
			CODE	DEFINITION
			RF	Referring

## IMPLEMENTATION

RENDERING PROVIDER SPECIALTY  
INFORMATION

Loop: 2310B — RENDERING PROVIDER NAME

Usage: SITUATIONAL — Usage Changed

Repeat: 1

Notes: 1. The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.

2. PRV02 qualifies PRV03.

New Note Added — 3. Required when adjudication is known to be impacted by provider taxonomy code.

Example: PRV\*PE\*ZZ\*203BA0200N~

## STANDARD

## PRV Provider Information

Level: Detail

Position: 255

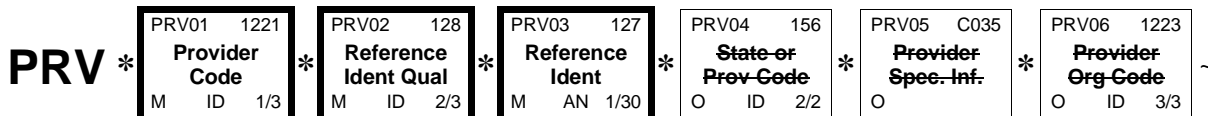
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

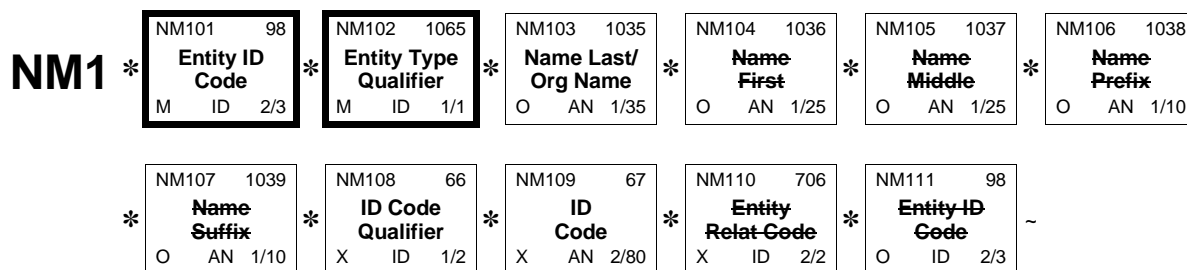
## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	Provider Code Code identifying the type of provider	M ID 1/3
			CODE	DEFINITION
			PE	Performing

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	M ID 2/3
			CODE DEFINITION	
			<b>QB Purchase Service Provider</b>	
REQUIRED	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity  SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			<b>1 Person</b>	
			<b>2 Non-Person Entity</b>	
SITUATIONAL	NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name	O AN 1/35
			Usage Changed New Note Added — Required if identifier is not used in NM109 or the corresponding REF segment.	
NOT USED	NM104	1036	<b>Name First</b>	O AN 1/25
NOT USED	NM105	1037	<b>Name Middle</b>	O AN 1/25
NOT USED	NM106	1038	<b>Name Prefix</b>	O AN 1/10
NOT USED	NM107	1039	<b>Name Suffix</b>	O AN 1/10
SITUATIONAL	NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67)  SYNTAX: P0809  Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.	X ID 1/2
			CODE DEFINITION	
			<b>24 Employer's Identification Number</b>	
			<b>34 Social Security Number</b>	

## IMPLEMENTATION

## OTHER PAYER PATIENT INFORMATION

Loop: 2330C — OTHER PAYER PATIENT INFORMATION Repeat: 1

Usage: SITUATIONAL

Repeat: 1

- Notes:
1. Required when it is necessary, in COB situations, to send one or more payer-specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330 loop are those patient ID's which belong to non-destination (COB) payers. The patient ID(s) for the destination payer are carried in the 2010CA loop NM1 and REF segments. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling non-destination payer patient identifiers and other COB elements.
  2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.

Example: NM1\*QC\*1\*\*\*\*\*MI\*6677U801~

## STANDARD

## NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 Repeat: 10

Requirement: Optional

Max Use: 1

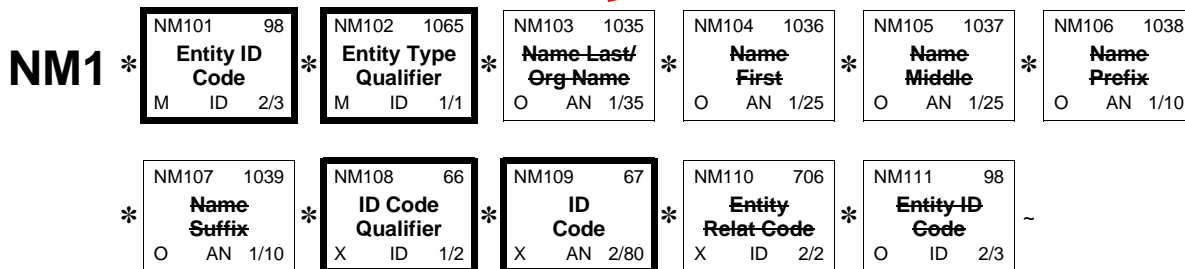
Purpose: To supply the full name of an individual or organizational entity

Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

- Syntax:
1. **P0809**  
If either NM108 or NM109 is present, then the other is required.
  2. **C1110**  
If NM111 is present, then NM110 is required.

## DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3
			CODE	DEFINITION		
			<b>QC</b>	<b>Patient</b>		
REQUIRED	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity  SEMANTIC: NM102 qualifies NM103.	M	ID	1/1
			CODE	DEFINITION		
			<b>1</b>	<b>Person</b>		
NOT USED	NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35
NOT USED	NM104	1036	<b>Name First</b>	O	AN	1/25
NOT USED	NM105	1037	<b>Name Middle</b>	O	AN	1/25
NOT USED	NM106	1038	<b>Name Prefix</b>	O	AN	1/10
NOT USED	NM107	1039	<b>Name Suffix</b>	O	AN	1/10
REQUIRED	NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67)  SYNTAX: P0809	X	ID	1/2
			CODE	DEFINITION		
			<b>MI</b>	<b>Member Identification Number</b>  The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.		
REQUIRED	NM109	67	<b>Identification Code</b> Code identifying a party or other code  INDUSTRY: <i>Other Payer Patient Primary Identifier</i> ALIAS: <i>Patient's Other Payer Primary Identification Number</i> SYNTAX: P0809	X	AN	2/80
NOT USED	NM110	706	<b>Entity Relationship Code</b>	X	ID	2/2
NOT USED	NM111	98	<b>Entity Identifier Code</b>	O	ID	2/3

## IMPLEMENTATION

## OTHER PAYER REFERRING PROVIDER

Loop: 2330D — OTHER PAYER REFERRING PROVIDER Repeat: 2

Usage: SITUATIONAL

Repeat: 1

- Notes:
1. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
  2. Because the usage of this segment is “Situational” this is not a syntactically required loop. If this loop is used, then this segment is a “Required” segment. See Appendix A for further details on ASC X12 syntax rules.
  3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example: NM1\*DN\*1~

## STANDARD

## NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 Repeat: 10

Requirement: Optional

Max Use: 1

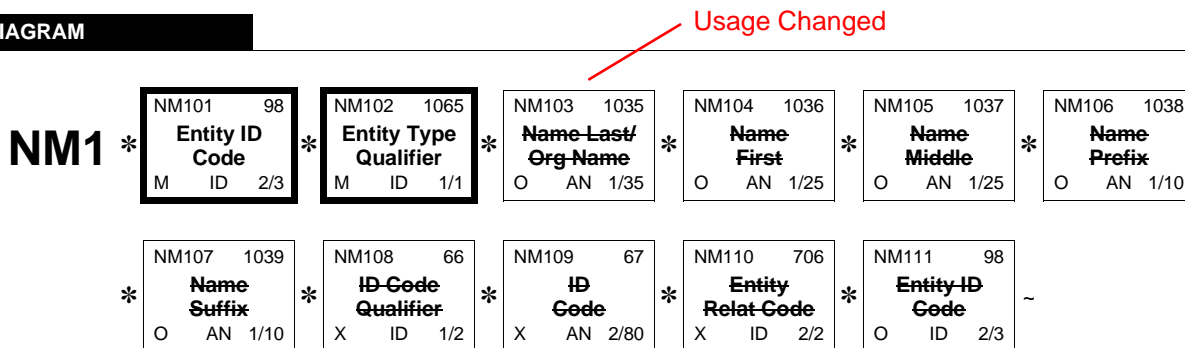
Purpose: To supply the full name of an individual or organizational entity

Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

- Syntax:
1. **P0809**  
If either NM108 or NM109 is present, then the other is required.
  2. **C1110**  
If NM111 is present, then NM110 is required.

## DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES								
REQUIRED	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>DN</td><td><b>Referring Provider</b> Use on first iteration of this loop. Use if loop is used only once.</td></tr><tr><td>P3</td><td><b>Primary Care Provider</b> Use only if loop is used twice. Use only on second iteration of this loop.</td></tr></table>	CODE	DEFINITION	DN	<b>Referring Provider</b> Use on first iteration of this loop. Use if loop is used only once.	P3	<b>Primary Care Provider</b> Use only if loop is used twice. Use only on second iteration of this loop.			
CODE	DEFINITION											
DN	<b>Referring Provider</b> Use on first iteration of this loop. Use if loop is used only once.											
P3	<b>Primary Care Provider</b> Use only if loop is used twice. Use only on second iteration of this loop.											
REQUIRED	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity  SEMANTIC: NM102 qualifies NM103.	M	ID	1/1						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td><b>Person</b></td></tr><tr><td>2</td><td><b>Non-Person Entity</b></td></tr></table>	CODE	DEFINITION	1	<b>Person</b>	2	<b>Non-Person Entity</b>			
CODE	DEFINITION											
1	<b>Person</b>											
2	<b>Non-Person Entity</b>											
NOT USED	NM103	1035	Name Last or Organization Name	O	AN	1/35						
NOT USED	NM104	1036	Name First	O	AN	1/25						
NOT USED	NM105	1037	Name Middle	O	AN	1/25						
NOT USED	NM106	1038	Name Prefix	O	AN	1/10						
NOT USED	NM107	1039	Name Suffix	O	AN	1/10						
NOT USED	NM108	66	Identification Code Qualifier	X	ID	1/2						
NOT USED	NM109	67	Identification Code	X	AN	2/80						
NOT USED	NM110	706	Entity Relationship Code	X	ID	2/2						
NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3						

Usage Changed

Usage Changed

## IMPLEMENTATION

## OTHER PAYER RENDERING PROVIDER

Loop: 2330E — OTHER PAYER RENDERING PROVIDER Repeat: 1

Usage: SITUATIONAL

Repeat: 1

- Notes:
1. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
  2. Because the usage of this segment is “Situational” this is not a syntactically required loop. If this loop is used, then this segment is a “Required” segment. See Appendix A for further details on ASC X12 syntax rules.
  3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example: NM1\*82\*1~

## STANDARD

## NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 Repeat: 10

Requirement: Optional

Max Use: 1

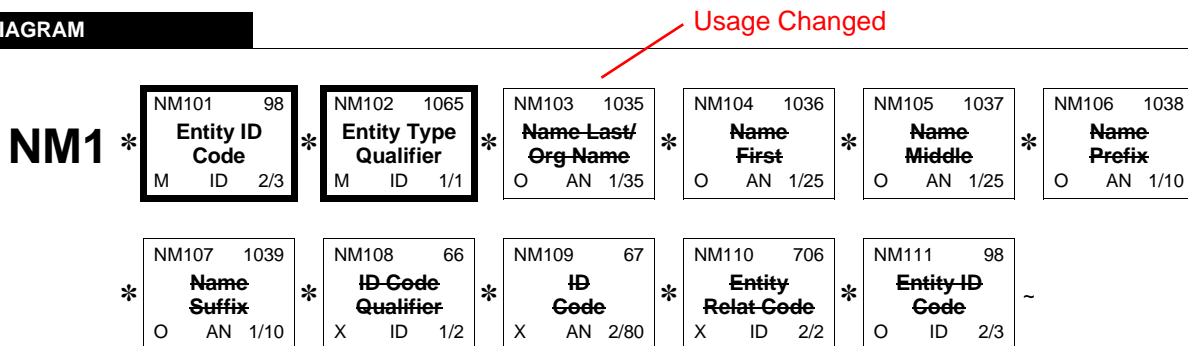
Purpose: To supply the full name of an individual or organizational entity

Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

- Syntax:
1. **P0809**  
If either NM108 or NM109 is present, then the other is required.
  2. **C1110**  
If NM111 is present, then NM110 is required.

## DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3
			CODE	DEFINITION		
			82	Rendering Provider		
REQUIRED	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity  SEMANTIC: NM102 qualifies NM103.	M	ID	1/1
			CODE	DEFINITION		
			1	Person		
			2	Non-Person Entity		
NOT USED	NM103	1035	Name Last or Organization Name	O	AN	1/35
NOT USED	NM104	1036	Name First	O	AN	1/25
NOT USED	NM105	1037	Name Middle	O	AN	1/25
NOT USED	NM106	1038	Name Prefix	O	AN	1/10
NOT USED	NM107	1039	Name Suffix	O	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X	ID	1/2
NOT USED	NM109	67	Identification Code	X	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3

Usage Changed

## IMPLEMENTATION

OTHER PAYER PURCHASED SERVICE  
PROVIDER

Loop: 2330F — OTHER PAYER PURCHASED SERVICE PROVIDER Repeat: 1

Usage: SITUATIONAL

Repeat: 1

- Notes:
1. Because the usage of this segment is “Situational” this is not a syntactically required loop. If this loop is used, then this segment is a “Required” segment. See Appendix A for further details on ASC X12 syntax rules.
  2. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
  3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example: NM1\*QB\*2~

## STANDARD

**NM1** Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 Repeat: 10

Requirement: Optional

Max Use: 1

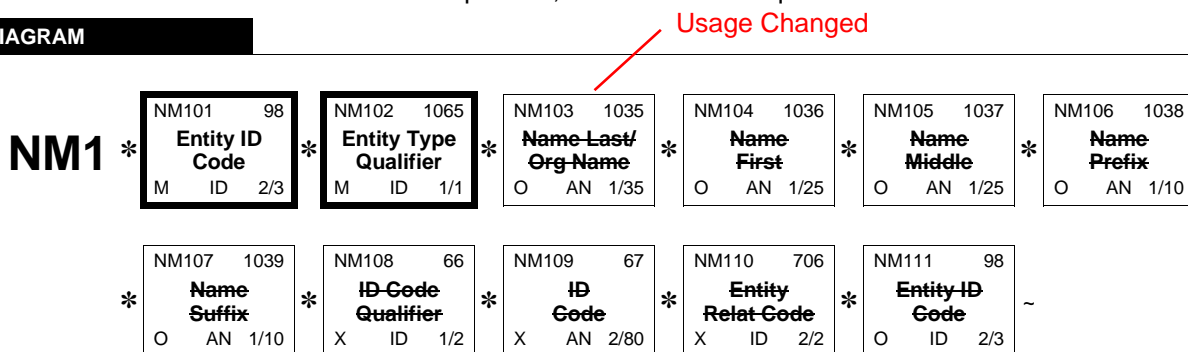
Purpose: To supply the full name of an individual or organizational entity

Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

- Syntax:
1. **P0809**  
If either NM108 or NM109 is present, then the other is required.
  2. **C1110**  
If NM111 is present, then NM110 is required.

## DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3
			CODE	DEFINITION		
			<b>QB</b>	<b>Purchase Service Provider</b>		
REQUIRED	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity  SEMANTIC: NM102 qualifies NM103.	M	ID	1/1
			CODE	DEFINITION		
			<b>1</b>	<b>Person</b>		
			<b>2</b>	<b>Non-Person Entity</b>		
NOT USED	NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35
NOT USED	NM104	1036	<b>Name First</b>	O	AN	1/25
NOT USED	NM105	1037	<b>Name Middle</b>	O	AN	1/25
NOT USED	NM106	1038	<b>Name Prefix</b>	O	AN	1/10
NOT USED	NM107	1039	<b>Name Suffix</b>	O	AN	1/10
NOT USED	NM108	66	<b>Identification Code Qualifier</b>	X	ID	1/2
NOT USED	NM109	67	<b>Identification Code</b>	X	AN	2/80
NOT USED	NM110	706	<b>Entity Relationship Code</b>	X	ID	2/2
NOT USED	NM111	98	<b>Entity Identifier Code</b>	O	ID	2/3

Usage Changed

## IMPLEMENTATION

## OTHER PAYER SERVICE FACILITY LOCATION

Loop: 2330G — OTHER PAYER SERVICE FACILITY LOCATION Repeat: 1

Usage: SITUATIONAL

Repeat: 1

- Notes:
1. Because the usage of this segment is “Situational” this is not a syntactically required loop. If this loop is used, then this segment is a “Required” segment. See Appendix A for further details on ASC X12 syntax rules.
  2. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
  3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example: NM1\*TL\*2~

## STANDARD

## NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 Repeat: 10

Requirement: Optional

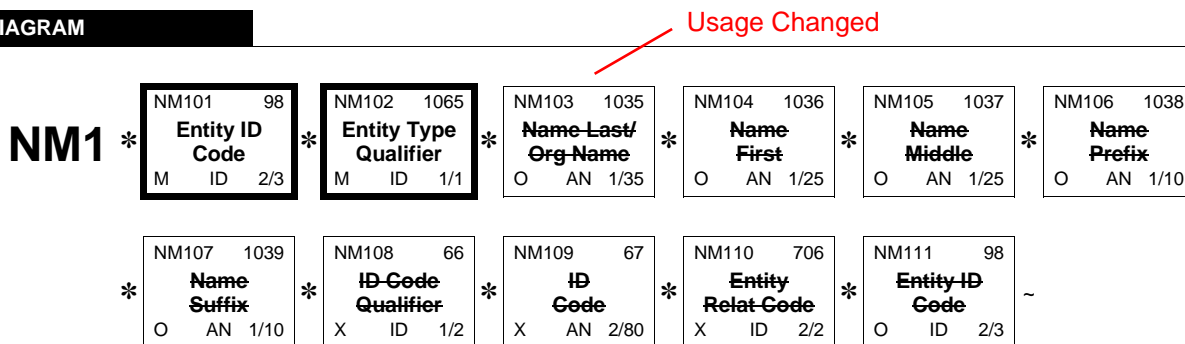
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes: 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

- Syntax:
1. **P0809**  
If either NM108 or NM109 is present, then the other is required.
  2. **C1110**  
If NM111 is present, then NM110 is required.

## DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3
			CODE	DEFINITION		
			77	<b>Service Location</b> Use when other codes in this element do not apply.		
			FA	<b>Facility</b>		
			LI	<b>Independent Lab</b>		
			TL	<b>Testing Laboratory</b>		
REQUIRED	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity  SEMANTIC: NM102 qualifies NM103.	M	ID	1/1
			CODE	DEFINITION		
			2	<b>Non-Person Entity</b>		
NOT USED	NM103	1035	Name Last or Organization Name	O	AN	1/35
NOT USED	NM104	1036	Name First	O	AN	1/25
NOT USED	NM105	1037	Name Middle	O	AN	1/25
NOT USED	NM106	1038	Name Prefix	O	AN	1/10
NOT USED	NM107	1039	Name Suffix	O	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X	ID	1/2
NOT USED	NM109	67	Identification Code	X	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3

Usage Changed

## IMPLEMENTATION

## OTHER PAYER SUPERVISING PROVIDER

Loop: 2330H — OTHER PAYER SUPERVISING PROVIDER Repeat: 1

Usage: SITUATIONAL

Repeat: 1

- Notes:
1. Because the usage of this segment is “Situational” this is not a syntactically required loop. If this loop is used, then this segment is a “Required” segment. See Appendix A for further details on ASC X12 syntax rules.
  2. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
  3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example: NM1\*DQ\*1~

## STANDARD

## NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 Repeat: 10

Requirement: Optional

Max Use: 1

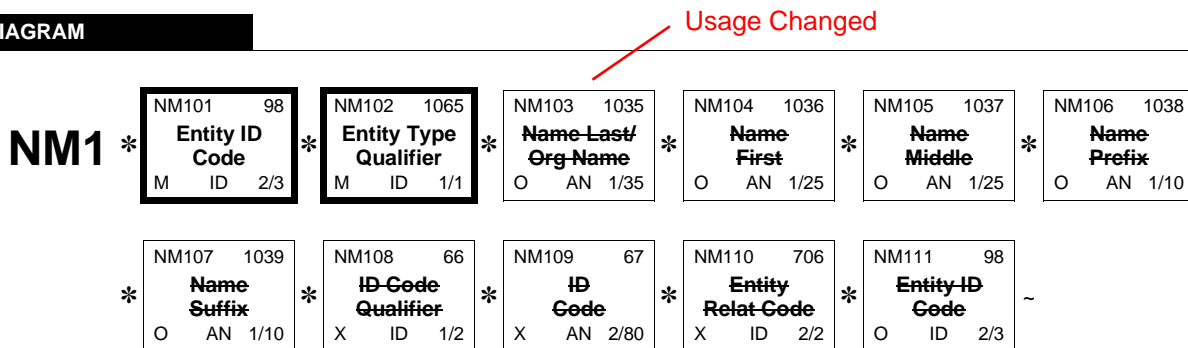
Purpose: To supply the full name of an individual or organizational entity

Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

- Syntax:
1. **P0809**  
If either NM108 or NM109 is present, then the other is required.
  2. **C1110**  
If NM111 is present, then NM110 is required.

## DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3
			CODE	DEFINITION		
			DQ	Supervising Physician		
REQUIRED	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity  SEMANTIC: NM102 qualifies NM103.	M	ID	1/1
			CODE	DEFINITION		
			1	Person		
NOT USED	NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35
NOT USED	NM104	1036	<b>Name First</b>	O	AN	1/25
NOT USED	NM105	1037	<b>Name Middle</b>	O	AN	1/25
NOT USED	NM106	1038	<b>Name Prefix</b>	O	AN	1/10
NOT USED	NM107	1039	<b>Name Suffix</b>	O	AN	1/10
NOT USED	NM108	66	<b>Identification Code Qualifier</b>	X	ID	1/2
NOT USED	NM109	67	<b>Identification Code</b>	X	AN	2/80
NOT USED	NM110	706	<b>Entity Relationship Code</b>	X	ID	2/2
NOT USED	NM111	98	<b>Entity Identifier Code</b>	O	ID	2/3

Usage Changed

**REQUIRED**      **SV101 - 1**      **235**      **Product/Service ID Qualifier**      **M**      **ID**      **2/2**  
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

*INDUSTRY: Product or Service ID Qualifier*

CODE	DEFINITION
HC	<b>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</b> <b>Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.</b>  CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
IV	<b>Home Infusion EDI Coalition (HIEC) Product/Service Code</b> <b>This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used:</b> <b>1) If a new rule names HIEC as an allowable code set under HIPAA.</b> <b>2) For Property &amp; Casualty claims/encounters that are not covered under HIPAA.</b>  CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List
N4	<b>National Drug Code in 5-4-2 Format</b> <b>Only used if J Codes are not allowed for use under HIPAA.</b>  CODE SOURCE 240: National Drug Code by Format
ZZ	<b>Mutually Defined</b> <b>Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.</b>

**REQUIRED**      **SV101 - 2**      **234**      **Product/Service ID**      **M**      **AN**      **1/48**  
Identifying number for a product or service

*INDUSTRY: Procedure Code*

**NSF Reference:**

**FA0-09.0, FB0-15.0, GU0-07.0**

**SITUATIONAL**      **SV101 - 3**      **1339**      **Procedure Modifier**      **O**      **AN**      **2/2**  
This identifies special circumstances related to the performance of the service, as defined by trading partners

*ALIAS: Procedure Modifier 1*

**NSF Reference:**

**FA0-10.0, GU0-08.0**

**Use this modifier for the first procedure code modifier.**

**Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**

<b>REQUIRED</b>	<b>SV103</b>	<b>355</b>	<b>Unit or Basis for Measurement Code</b>	<b>X</b>	<b>ID</b>	<b>2/2</b>
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken						

SYNTAX: P0304

**NSF Reference:****FA0-50.0****FA0-50.0 is only used in Medicare COB payer-to-payer situations.**

CODE	DEFINITION
<b>F2</b>	<b>International Unit</b> International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors).
<b>MJ</b>	<b>Minutes</b> Required for Anesthesia claims.
<b>UN</b>	<b>Unit</b>

New Note Added

<b>REQUIRED</b>	<b>SV104</b>	<b>380</b>	<b>Quantity</b>	<b>X</b>	<b>R</b>	<b>1/15</b>
Numeric value of quantity						

*INDUSTRY: Service Unit Count**ALIAS: Units or Minutes*

SYNTAX: P0304

**NSF Reference:****FA0-18.0, FA0-19.0, FB0-16.0****Note: If a decimal is needed to report units, include it in this element, e.g., "15.6".**

<b>SITUATIONAL</b>	<b>SV109</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response <i>INDUSTRY: Emergency Indicator</i> <i>SEMANTIC:</i> SV109 is the emergency-related indicator; a “Y” value indicates service provided was emergency related; an “N” value indicates service provided was not emergency related. <b>NSF Reference:</b> <b>FA0-20.0</b> <b>Required when the service is known to be an emergency by the provider.</b> <b>Emergency definition: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.</b>	<b>O</b>	<b>ID</b>	<b>1/1</b>
<b>Usage Changed</b>						
<b>New Note Added</b>						
<b>Code N Deleted</b>						
<b>NOT USED</b>	<b>SV110</b>	<b>1340</b>	<b>Multiple Procedure Code</b>	<b>O</b>	<b>ID</b>	<b>1/2</b>
<b>SITUATIONAL</b>	<b>SV111</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response <i>INDUSTRY: EPSDT Indicator</i> <i>SEMANTIC:</i> SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a “Y” value indicates EPSDT involvement; an “N” value indicates no EPSDT involvement. <b>NSF Reference:</b> <b>FB0-22.0</b> <b>Required if Medicaid services are the result of a screening referral.</b>	<b>O</b>	<b>ID</b>	<b>1/1</b>
<b>Code N Deleted</b>						
<b>SITUATIONAL</b>	<b>SV112</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response <i>INDUSTRY: Family Planning Indicator</i> <i>SEMANTIC:</i> SV112 is the family planning involvement indicator. A “Y” value indicates family planning services involvement; an “N” value indicates no family planning services involvement. <b>NSF Reference:</b> <b>FB0-23.0</b> <b>Required if applicable for Medicaid claims.</b>	<b>O</b>	<b>ID</b>	<b>1/1</b>
<b>NOT USED</b>	<b>SV113</b>	<b>1364</b>	<b>Review Code</b>	<b>O</b>	<b>ID</b>	<b>1/2</b>
<b>NOT USED</b>	<b>SV114</b>	<b>1341</b>	<b>National or Local Assigned Review Value</b>	<b>O</b>	<b>AN</b>	<b>1/2</b>

IMPLEMENTATION

## DURABLE MEDICAL EQUIPMENT SERVICE

Loop: 2400 — SERVICE LINE

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when reporting rental and purchase price information for durable medical equipment.

Example: SV5\*HC:A4631\*DA\*30\*50\*5000\*4~

STANDARD

### SV5 Durable Medical Equipment Service

Level: Detail

Position: 400

Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To specify the claim service detail for durable medical equipment

- Syntax: 1. **R0405**  
At least one of SV504 or SV505 is required.
2. **C0604**  
If SV506 is present, then SV504 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SV501	C003	COMPOSITE MEDICAL PROCEDURE IDENTIFIER To identify a medical procedure by its standardized codes and applicable modifiers	M

REQUIRED	SV501 - 1	235	<b>Product/Service ID Qualifier</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234)  <i>INDUSTRY: Procedure Identifier</i>	M	ID	2/2				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>HC</td><td><b>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</b>  CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System</td></tr></table>							CODE	DEFINITION	HC	<b>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</b>  CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
CODE	DEFINITION									
HC	<b>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</b>  CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System									
REQUIRED	SV501 - 2	234	<b>Product/Service ID</b> Identifying number for a product or service  <i>INDUSTRY: Procedure Code</i> <b>This value must be the same as that reported in SV101-2.</b>	M	AN	1/48				
NOT USED	SV501 - 3	1339	<b>Procedure Modifier</b>	O	AN	2/2				
NOT USED	SV501 - 4	1339	<b>Procedure Modifier</b>	O	AN	2/2				
NOT USED	SV501 - 5	1339	<b>Procedure Modifier</b>	O	AN	2/2				
NOT USED	SV501 - 6	1339	<b>Procedure Modifier</b>	O	AN	2/2				
NOT USED	SV501 - 7	352	<b>Description</b>	O	AN	1/80				
REQUIRED	SV502	355	<b>Unit or Basis for Measurement Code</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	M	ID	2/2				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>DA</td><td><b>Days</b></td></tr></table>							CODE	DEFINITION	DA	<b>Days</b>
CODE	DEFINITION									
DA	<b>Days</b>									
REQUIRED	SV503	380	<b>Quantity</b> Numeric value of quantity  <i>INDUSTRY: Length of Medical Necessity</i> SEMANTIC: SV503 is the length of medical treatment required.	M	R	1/15				
SITUATIONAL	SV504	782	<b>Monetary Amount</b> Monetary amount  <i>INDUSTRY: DME Rental Price</i> SYNTAX: R0405, C0604 SEMANTIC: SV504 is the rental price.	X	R	1/18				
SITUATIONAL	SV505	782	<b>Monetary Amount</b> Monetary amount  <i>INDUSTRY: DME Purchase Price</i> SYNTAX: R0405 SEMANTIC: SV505 is the purchase price.	X	R	1/18				
SITUATIONAL	SV506	594	<b>Frequency Code</b> Code indicating frequency or type of payment  <i>INDUSTRY: Rental Unit Price Indicator</i> SYNTAX: C0604 SEMANTIC: SV506 is the frequency at which the rental equipment is billed.	O	ID	1/1				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td><b>Weekly</b></td></tr></table>							CODE	DEFINITION	1	<b>Weekly</b>
CODE	DEFINITION									
1	<b>Weekly</b>									

			4	Monthly			
			6	Daily			
NOT USED	SV507	923	Prognosis Code			O ID	1/1

## IMPLEMENTATION

SPINAL MANIPULATION SERVICE  
INFORMATION

Loop: 2400 — SERVICE LINE

Usage: SITUATIONAL

Repeat: 5

Notes: 1. Required on all Medicare Part B chiropractic claims involving spinal manipulation.

Note  
Changed

Example: CR2\*\*\*\*\*M\*\*\*Y~ ————— Example Changed

## STANDARD

## CR2 Chiropractic Certification

Level: Detail

Position: 430

Loop: 2400

Requirement: Optional

Max Use: 5

Purpose: To supply information related to the chiropractic service rendered to a patient

Syntax: 1. P0102

If either CR201 or CR202 is present, then the other is required.

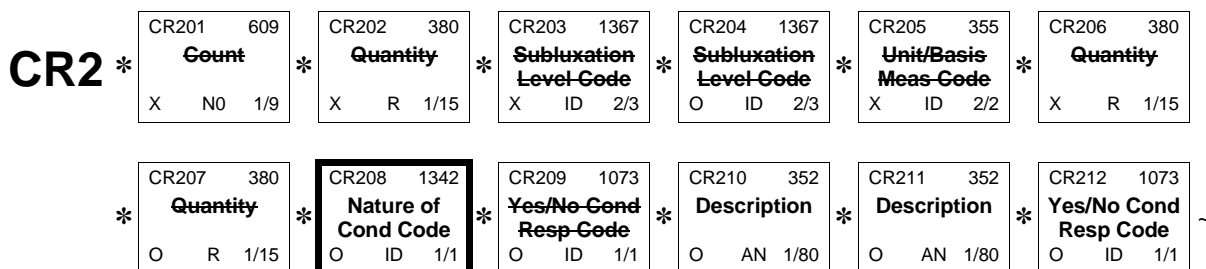
2. C0403

If CR204 is present, then CR203 is required.

3. P0506

If either CR205 or CR206 is present, then the other is required.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	CR201	609	Count	X NO 1/9
NOT USED	CR202	380	Quantity	X R 1/15
NOT USED	CR203	1367	Subluxation Level Code	X ID 2/3
NOT USED	CR204	1367	Subluxation Level Code	O ID 2/3

Usage Changed

NOT USED	CR205	355	Unit or Basis for Measurement Code	X	ID	2/2
NOT USED	CR206	380	Quantity	X	R	1/15
NOT USED	CR207	380	Quantity	O	R	1/15
REQUIRED	CR208	1342	Nature of Condition Code	O	ID	1/1

Usage Changed

**INDUSTRY:** *Patient Condition Code*

**ALIAS:** *Nature of Condition Code. Spinal Manipulation*

**NSF Reference:**

**GC0-11.0**

CODE	DEFINITION
A	Acute Condition
C	Chronic Condition
D	Non-acute
E	Non-Life Threatening
F	Routine
G	Symptomatic
M	Acute Manifestation of a Chronic Condition

NOT USED	CR209	1073	Yes/No Condition or Response Code	O	ID	1/1
SITUATIONAL	CR210	352	Description	O	AN	1/80

A free-form description to clarify the related data elements and their content

**INDUSTRY:** *Patient Condition Description*

**ALIAS:** *Patient Condition Description, Chiropractic*

**SEMANTIC:** CR210 is a description of the patient's condition.

**NSF Reference:**

**GC0-14.0**

Used at discretion of submitter.

SITUATIONAL	CR211	352	Description	O	AN	1/80
-------------	-------	-----	-------------	---	----	------

A free-form description to clarify the related data elements and their content

**INDUSTRY:** *Patient Condition Description*

**ALIAS:** *Patient Condition Description, Chiropractic*

**SEMANTIC:** CR211 is an additional description of the patient's condition.

**NSF Reference:**

**GC0-14.0**

Used at discretion of submitter.

**SITUATIONAL** **CR212** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**

Usage Changed

Code indicating a Yes or No condition or response

**INDUSTRY:** *X-ray Availability Indicator*

**ALIAS:** *X-ray Availability Indicator, Chiropractic*

**SEMANTIC:** CR212 is X-rays availability indicator. A "Y" value indicates X-rays are maintained and available for carrier review; an "N" value indicates X-rays are not maintained and available for carrier review.

**NSF Reference:**

**GC0-15.0**

New Note Added

**Required for service dates prior to January 1, 2000.**

CODE	DEFINITION
N	No
Y	Yes

## IMPLEMENTATION

## DATE - DATE LAST SEEN

Loop: 2400 — SERVICE LINE

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when Medicare Part B claims involve services from an independent physical therapist, occupational therapist, or physician services involving routine foot care and is different than the date listed at the claim level (Loop-ID 2300).

Note 1. Changed

2. The total number of DTP segments in the 2400 loop cannot exceed 15.

Example: DTP\*304\*D8\*19970813~

## STANDARD

## DTP Date or Time or Period

Level: Detail

Position: 455

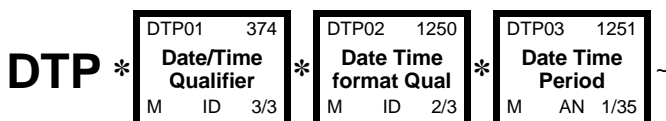
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time  <i>INDUSTRY: <b>Date Time Qualifier</b></i>	M	ID	3/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>304</td><td><b>Latest Visit or Consultation</b></td></tr></table>	CODE	DEFINITION	304	<b>Latest Visit or Consultation</b>			
CODE	DEFINITION									
304	<b>Latest Visit or Consultation</b>									
REQUIRED	DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format  <b>SEMANTIC:</b> DTP02 is the date or time or period format that will appear in DTP03.	M	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>D8</td><td><b>Date Expressed in Format CCYYMMDD</b></td></tr></table>	CODE	DEFINITION	D8	<b>Date Expressed in Format CCYYMMDD</b>			
CODE	DEFINITION									
D8	<b>Date Expressed in Format CCYYMMDD</b>									

IMPLEMENTATION

## TEST RESULT

Loop: 2400 — SERVICE LINE

Usage: SITUATIONAL

Repeat: 20

Notes: 1. Required on service lines for Dialysis for ESRD. Use R1, R2, R3, or R4 to qualify the Hemoglobin, Hematocrit, Epoetin Starting Dosage and Creatinine test results.

Note 1. Changed

2. Required on Oxygen Therapy service lines to report the Oxygen Saturation measurement from the Certificate of Medical Necessity (CMN). Use ZO qualifier.

New Notes Added

3. Required on Oxygen Therapy service lines to report the Arterial Blood Gas measurement from the Certificate of Medical Necessity (CMN). Use GRA qualifier.

4. Required on DMERC service lines to report the Patient's Height from the Certificate of Medical Necessity (CMN). Use HT qualifier.

Example: MEA\*TR\*R1\*113.4~

STANDARD

## MEA Measurements

Level: Detail

Position: 462

Loop: 2400

Requirement: Optional

Max Use: 20

Purpose: To specify physical measurements or counts, including dimensions, tolerances, variances, and weights

Syntax: 1. **R03050608**

At least one of MEA03, MEA05, MEA06 or MEA08 is required.

2. **C0504**

If MEA05 is present, then MEA04 is required.

3. **C0604**

If MEA06 is present, then MEA04 is required.

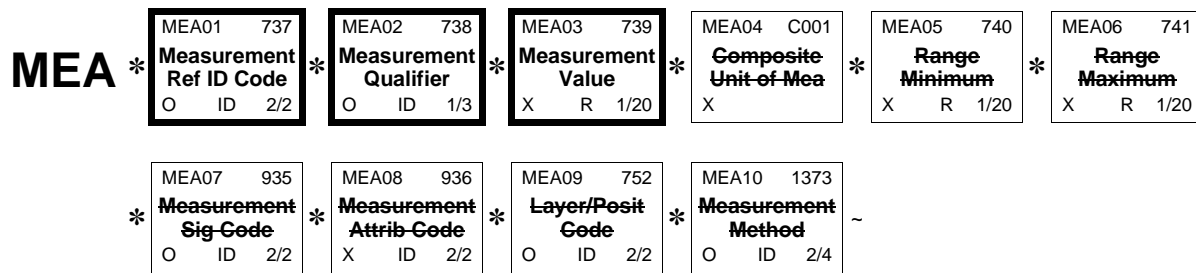
4. **L07030506**

If MEA07 is present, then at least one of MEA03, MEA05 or MEA06 are required.

5. **E0803**

Only one of MEA08 or MEA03 may be present.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																		
REQUIRED	MEA01	737	<b>Measurement Reference ID Code</b> Code identifying the broad category to which a measurement applies <i>INDUSTRY: Measurement Reference Identification Code</i> <i>ALIAS: Measurement identifier</i>	O	ID	2/2																
			<table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>OG</td><td>Original Starting dosage</td></tr><tr><td>TR</td><td>Test Results</td></tr></tbody></table>	CODE	DEFINITION	OG	Original Starting dosage	TR	Test Results													
CODE	DEFINITION																					
OG	Original Starting dosage																					
TR	Test Results																					
REQUIRED	MEA02	738	<b>Measurement Qualifier</b> Code identifying a specific product or process characteristic to which a measurement applies	O	ID	1/3																
			<table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>GRA</td><td>Gas Test Rate</td></tr><tr><td>HT</td><td>Height</td></tr><tr><td>R1</td><td>Hemoglobin</td></tr><tr><td>R2</td><td>Hematocrit</td></tr><tr><td>R3</td><td>Epoetin Starting Dosage</td></tr><tr><td>R4</td><td>Creatin</td></tr><tr><td>ZO</td><td>Oxygen</td></tr></tbody></table>	CODE	DEFINITION	GRA	Gas Test Rate	HT	Height	R1	Hemoglobin	R2	Hematocrit	R3	Epoetin Starting Dosage	R4	Creatin	ZO	Oxygen			
CODE	DEFINITION																					
GRA	Gas Test Rate																					
HT	Height																					
R1	Hemoglobin																					
R2	Hematocrit																					
R3	Epoetin Starting Dosage																					
R4	Creatin																					
ZO	Oxygen																					
			Code CON Deleted																			
REQUIRED	MEA03	739	<b>Measurement Value</b> The value of the measurement <i>INDUSTRY: Test Results</i> SYNTAX: R03050608, L07030506, E0803 NSF Reference:	X	R	1/20																
			FA0-42.0 - Hemoglobin, FA0-43.0 - Hematocrit, FA0-45.0 - Epoetin Starting Dosage, FA0-47.0 - Creatin, GX0-17.0 - Arterial Blood Gas on 4 liters/minute, GX0-18.0 - Oxygen Saturation on 4 liters/minute, GU0-16.0 - Patient Height																			
			Note Changed																			

## IMPLEMENTATION

## MAMMOGRAPHY CERTIFICATION NUMBER

Loop: 2400 — SERVICE LINE

Usage: SITUATIONAL

Repeat: 1

Note Changed ~~Notes:~~ 1. Required when mammography services are rendered by a certified mammography provider.

Example: REF\*EW\*T554~

## STANDARD

## REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

Requirement: Optional

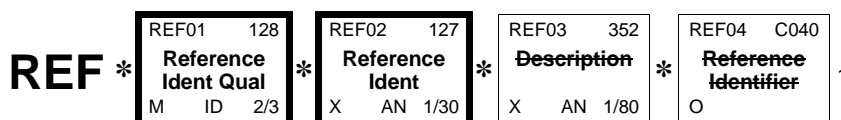
Max Use: 30

Purpose: To specify identifying information

Syntax: 1. R0203

At least one of REF02 or REF03 is required.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3
			CODE	DEFINITION
			EW	Mammography Certification Number
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  INDUSTRY: Mammography Certification Number  SYNTAX: R0203  NSF Reference: FA0-31.0	X AN 1/30
NOT USED	REF03	352	Description	X AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

## IMPLEMENTATION

## PURCHASED SERVICE INFORMATION

Loop: 2400 — SERVICE LINE

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Using the PS1 segment indicates that services were purchased from another source.

Note Changed — 2. Required on service lines when the purchased service charge amount is necessary for processing.

New Note Added — 3. Use this segment on vision claims when the acquisition cost of lenses is known to impact adjudication or reimbursement.

Example: PS1\*PN222222\*110~

## STANDARD

## PS1 Purchase Service

Level: Detail

Position: 488

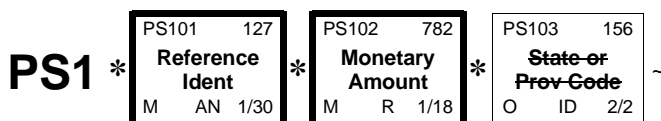
Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To specify the information about services that are purchased

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PS101	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  <i>INDUSTRY: Purchased Service Provider Identifier</i>  SEMANTIC: PS101 is provider identification number.  NSF Reference: FB0-11.0	M AN 1/30

IMPLEMENTATION

## DRUG IDENTIFICATION

Loop: 2410 — DRUG IDENTIFICATION Repeat: 25

Usage: SITUATIONAL

Repeat: 1

- Notes:
1. Required when NDC usage is necessary to further define the service provided in SV101-2.
  2. Use Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1.

Example: LIN\*\*N4\*01234567891~

STANDARD

### LIN Item Identification

Level: Detail

Position: 494

Loop: 2410 Repeat: >1

Requirement: Optional

Max Use: 1

Purpose: To specify basic item identification data

Set Notes: 1. Loop 2410 contains compound drug components, quantities and prices.

- Syntax:
1. **P0405**  
If either LIN04 or LIN05 is present, then the other is required.
  2. **P0607**  
If either LIN06 or LIN07 is present, then the other is required.
  3. **P0809**  
If either LIN08 or LIN09 is present, then the other is required.
  4. **P1011**  
If either LIN10 or LIN11 is present, then the other is required.
  5. **P1213**  
If either LIN12 or LIN13 is present, then the other is required.
  6. **P1415**  
If either LIN14 or LIN15 is present, then the other is required.
  7. **P1617**  
If either LIN16 or LIN17 is present, then the other is required.
  8. **P1819**  
If either LIN18 or LIN19 is present, then the other is required.
  9. **P2021**  
If either LIN20 or LIN21 is present, then the other is required.
  10. **P2223**  
If either LIN22 or LIN23 is present, then the other is required.

**11. P2425**

If either LIN24 or LIN25 is present, then the other is required.

**12. P2627**

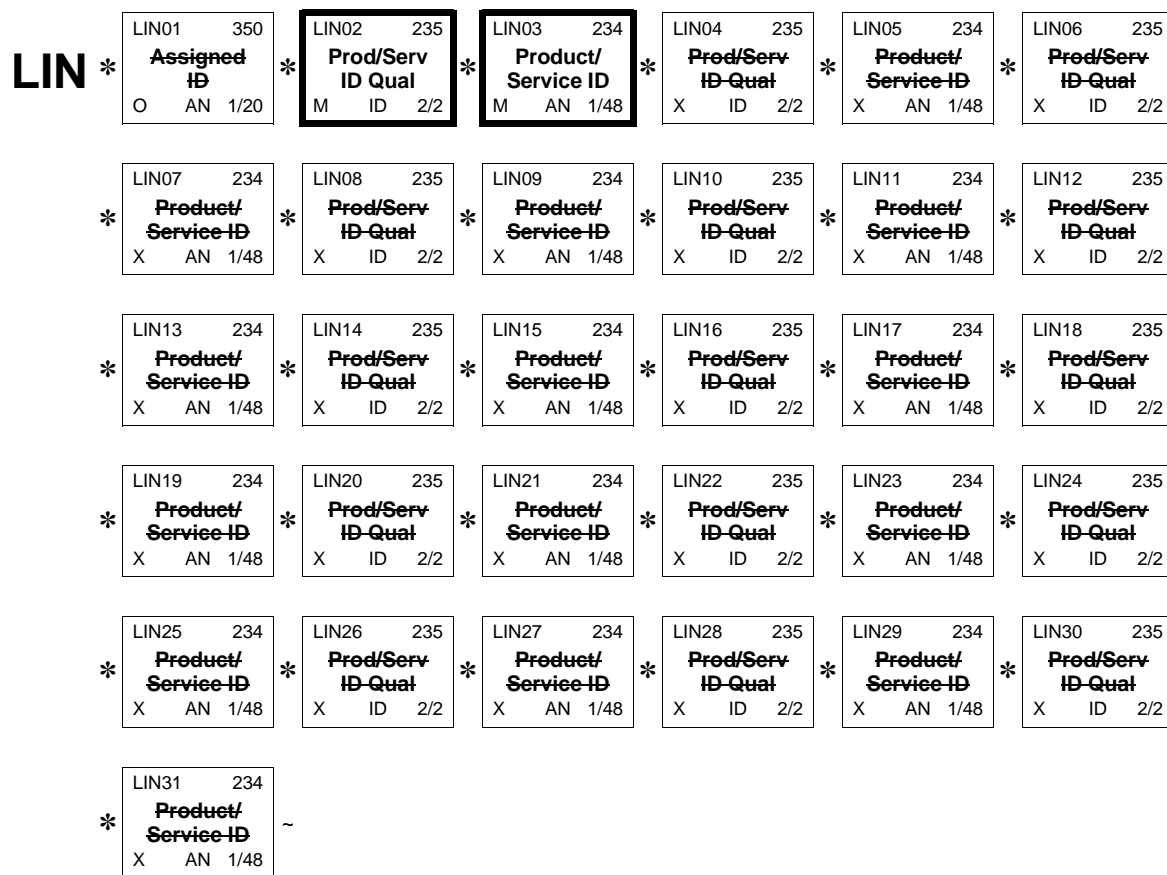
If either LIN26 or LIN27 is present, then the other is required.

**13. P2829**

If either LIN28 or LIN29 is present, then the other is required.

**14. P3031**

If either LIN30 or LIN31 is present, then the other is required.

**DIAGRAM****ELEMENT SUMMARY**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	LIN01	350	Assigned Identification	O AN 1/20

REQUIRED	LIN02	235	<b>Product/Service ID Qualifier</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234)  COMMENT: LIN02 through LIN31 provide for fifteen different product/service IDs for each item. For example: Case, Color, Drawing No., U.P.C. No., ISBN No., Model No., or SKU.	M	ID	2/2
<div> <div>CODE</div> <div>DEFINITION</div> </div>						
<div> <div>N4</div> <div>National Drug Code in 5-4-2 Format</div> </div>						
CODE SOURCE 240: National Drug Code by Format						
REQUIRED	LIN03	234	<b>Product/Service ID</b> Identifying number for a product or service	M	AN	1/48
ALIAS: <b>National Drug Code</b>						
NOT USED	LIN04	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN05	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN06	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN07	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN08	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN09	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN10	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN11	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN12	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN13	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN14	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN15	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN16	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN17	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN18	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN19	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN20	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN21	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN22	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN23	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN24	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN25	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN26	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN27	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN28	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN29	234	<b>Product/Service ID</b>	X	AN	1/48
NOT USED	LIN30	235	<b>Product/Service ID Qualifier</b>	X	ID	2/2
NOT USED	LIN31	234	<b>Product/Service ID</b>	X	AN	1/48

## IMPLEMENTATION

## DRUG PRICING

Loop: 2410 — DRUG IDENTIFICATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when it is necessary to provide a price specific to the NDC provided in LIN03 that is different than the price reported in SV102.

Example: CTP\*\*\*1.15\*2\*UN~

## STANDARD

## CTP Pricing Information

Level: Detail

Position: 495

Loop: 2410

Requirement: Optional

Max Use: 1

Purpose: To specify pricing information

Syntax: 1. **P0405**

If either CTP04 or CTP05 is present, then the other is required.

2. **C0607**

If CTP06 is present, then CTP07 is required.

3. **C0902**

If CTP09 is present, then CTP02 is required.

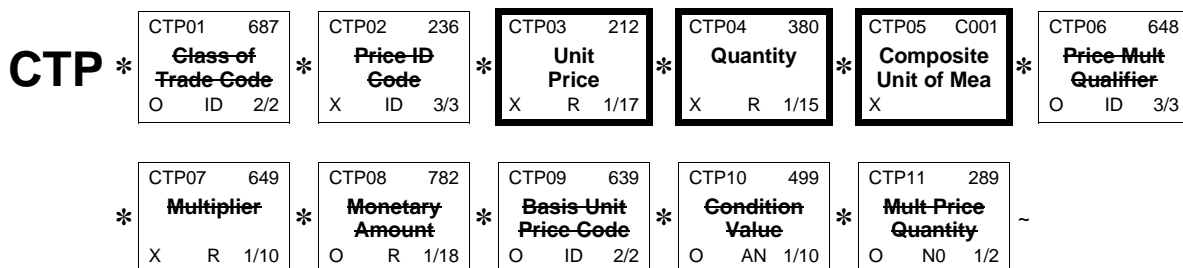
4. **C1002**

If CTP10 is present, then CTP02 is required.

5. **C1103**

If CTP11 is present, then CTP03 is required.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	CTP01	687	Class of Trade Code	O ID 2/2

NOT USED	CTP02	236	Price Identifier Code	X	ID	3/3										
REQUIRED	CTP03	212	Unit Price Price per unit of product, service, commodity, etc.  ALIAS: <b>Drug Unit Price</b>  SYNTAX: C1103	X	R	1/17										
REQUIRED	CTP04	380	Quantity Numeric value of quantity  ALIAS: <b>National Drug Unit Count</b>  SYNTAX: P0405	X	R	1/15										
REQUIRED	CTP05	C001	COMPOSITE UNIT OF MEASURE To identify a composite unit of measure  ALIAS: <b>Unit/Basis of Measurement</b>	X												
REQUIRED	CTP05 - 1	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken  ALIAS: <b>Code qualifier</b>	M	ID	2/2										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>GR</td><td>Gram</td></tr><tr><td>ME</td><td>Milligram</td></tr><tr><td>ML</td><td>Milliliter</td></tr><tr><td>UN</td><td>Unit</td></tr></table>							CODE	DEFINITION	GR	Gram	ME	Milligram	ML	Milliliter	UN	Unit
CODE	DEFINITION															
GR	Gram															
ME	Milligram															
ML	Milliliter															
UN	Unit															
NOT USED	CTP05 - 2	1018	Exponent	O	R	1/15										
NOT USED	CTP05 - 3	649	Multiplier	O	R	1/10										
NOT USED	CTP05 - 4	355	Unit or Basis for Measurement Code	O	ID	2/2										
NOT USED	CTP05 - 5	1018	Exponent	O	R	1/15										
NOT USED	CTP05 - 6	649	Multiplier	O	R	1/10										
NOT USED	CTP05 - 7	355	Unit or Basis for Measurement Code	O	ID	2/2										
NOT USED	CTP05 - 8	1018	Exponent	O	R	1/15										
NOT USED	CTP05 - 9	649	Multiplier	O	R	1/10										
NOT USED	CTP05 - 10	355	Unit or Basis for Measurement Code	O	ID	2/2										
NOT USED	CTP05 - 11	1018	Exponent	O	R	1/15										
NOT USED	CTP05 - 12	649	Multiplier	O	R	1/10										
NOT USED	CTP05 - 13	355	Unit or Basis for Measurement Code	O	ID	2/2										
NOT USED	CTP05 - 14	1018	Exponent	O	R	1/15										
NOT USED	CTP05 - 15	649	Multiplier	O	R	1/10										
NOT USED	CTP06	648	Price Multiplier Qualifier	O	ID	3/3										
NOT USED	CTP07	649	Multiplier	X	R	1/10										
NOT USED	CTP08	782	Monetary Amount	O	R	1/18										
NOT USED	CTP09	639	Basis of Unit Price Code	O	ID	2/2										
NOT USED	CTP10	499	Condition Value	O	AN	1/10										
NOT USED	CTP11	289	Multiple Price Quantity	O	N0	1/2										

## IMPLEMENTATION

## PRESCRIPTION NUMBER

Loop: 2410 — DRUG IDENTIFICATION

Usage: SITUATIONAL

Repeat: 1

- Notes: 1. Required if dispensing of the drug has been done with an assigned Rx number.
2. In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.

Example: REF\*XZ\*123456~

## STANDARD

## REF Reference Identification

Level: Detail

Position: 496

Loop: 2410

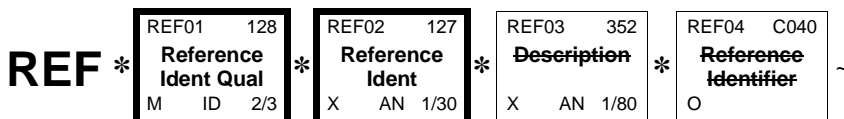
Requirement: Optional

Max Use: 1

Purpose: To specify identifying information

Syntax: 1. R0203  
At least one of REF02 or REF03 is required.

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification  ALIAS: <i>Code qualifier</i>	M ID 2/3
			CODE	DEFINITION
			XZ	Pharmacy Prescription Number

REQUIRED	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  <i>ALIAS: Prescription Number</i>  SYNTAX: R0203	X	AN	1/30
NOT USED	REF03	352	<b>Description</b>	X	AN	1/80
NOT USED	REF04	C040	<b>REFERENCE IDENTIFIER</b>	O		

## IMPLEMENTATION

RENDERING PROVIDER SPECIALTY  
INFORMATION

Loop: 2420A — RENDERING PROVIDER NAME

Usage: SITUATIONAL — Usage Changed

Repeat: 1

Notes: 1. PRV02 qualifies PRV03.

New Note Added — 2. Required when adjudication is known to be impacted by provider taxonomy code.

Example: PRV\*PE\*ZZ\*203BA050N~

## STANDARD

## PRV Provider Information

Level: Detail

Position: 505

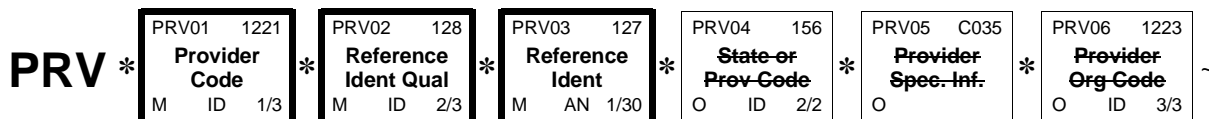
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	<b>Provider Code</b> Code identifying the type of provider	M ID 1/3
			CODE	DEFINITION
			PE	Performing

## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	SVD01	67	<b>Identification Code</b> Code identifying a party or other code  <i>INDUSTRY: Other Payer Primary Identifier</i>  <i>ALIAS: Other Payer identification code</i>  SEMANTIC: SVD01 is the payer identification code.  This number should match NM109 in Loop ID-2330B identifying Other Payer.	M	AN	2/80
REQUIRED	SVD02	782	<b>Monetary Amount</b> Monetary amount  <i>INDUSTRY: Service Line Paid Amount</i>  <i>ALIAS: Paid Amount</i>  SEMANTIC: SVD02 is the amount paid for this service line.  NSF Reference: FA0-52.0  Zero "0" is an acceptable value for this element.  The FA0-52.0 NSF crosswalk is only used in payer-to-payer COB situations.	M	R	1/18
REQUIRED	SVD03	C003	<b>COMPOSITE MEDICAL PROCEDURE IDENTIFIER</b> To identify a medical procedure by its standardized codes and applicable modifiers  <i>ALIAS: Procedure identifier</i>  This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transmission.	O		
REQUIRED	SVD03 - 1	235	<b>Product/Service ID Qualifier</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234)  <i>INDUSTRY: Product or Service ID Qualifier</i>	M	ID	2/2
		CODE	DEFINITION			
		HC	<b>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</b> Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.  CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System			

New Note Added

**IV Home Infusion EDI Coalition (HIEC) Product/Service Code**

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.

CODE SOURCE 513: Home Infusion EDI Coalition (HIEC)  
Product/Service Code List

Codes N1, N2 and N3 Deleted

New Note Added

**N4 National Drug Code in 5-4-2 Format**

Only used if J Codes are not allowed for use under HIPAA.

CODE SOURCE 240: National Drug Code by Format

**ZZ Mutually Defined**

Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.

**REQUIRED** SVD03 - 2

**234 Product/Service ID** M AN 1/48  
Identifying number for a product or service

INDUSTRY: *Procedure Code*

**SITUATIONAL** SVD03 - 3

**1339 Procedure Modifier** O AN 2/2  
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: *Procedure Modifier 1*

Use this modifier for the first procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

**SITUATIONAL** SVD03 - 4

**1339 Procedure Modifier** O AN 2/2  
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: *Procedure Modifier 2*

Use this modifier for the second procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

**SITUATIONAL** SVD03 - 5

**1339 Procedure Modifier** O AN 2/2  
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: *Procedure Modifier 3*

Use this modifier for the third procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

<b>SITUATIONAL</b>	<b>SVD03 - 6</b>	<b>1339</b>	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <i>ALIAS: Procedure Modifier 4</i> <b>Use this modifier for the fourth procedure code modifier.</b> <b>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</b>	<b>O</b>	<b>AN</b>	<b>2/2</b>
<b>SITUATIONAL</b>	<b>SVD03 - 7</b>	<b>352</b>	<b>Description</b> A free-form description to clarify the related data elements and their content <i>INDUSTRY: Procedure Code Description</i> <b>Required if SVC01-7 was returned in the 835 transaction.</b>	<b>O</b>	<b>AN</b>	<b>1/80</b>
<b>NOT USED</b>	<b>SVD04</b>	<b>234</b>	<b>Product/Service ID</b>	<b>O</b>	<b>AN</b>	<b>1/48</b>
<b>REQUIRED</b>	<b>SVD05</b>	<b>380</b>	<b>Quantity</b> Numeric value of quantity <i>INDUSTRY: Paid Service Unit Count</i> <i>ALIAS: Paid units of service</i> <i>SEMANTIC: SVD05 is the paid units of service.</i> <b>Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.</b>	<b>O</b>	<b>R</b>	<b>1/15</b>
<b>SITUATIONAL</b>	<b>SVD06</b>	<b>554</b>	<b>Assigned Number</b> Number assigned for differentiation within a transaction set <i>INDUSTRY: Bundled Line Number</i> <i>ALIAS: Bundled Line Number</i> <i>COMMENT: SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.</i> <b>Use the LX from this transaction which points to the bundled line.</b> <b>Required if payer bundled this service line.</b>	<b>O</b>	<b>N0</b>	<b>1/6</b>

Industry and Alias Names  
Changed

Notes Changed

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

<b>SYMBOL</b>	<b>TYPE</b>
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

**Matrix A4. Data Element Types**

#### **A.1.3.1.1**

### **Numeric**

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is "Nn" where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

#### **EXAMPLE**

A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

#### **A.1.3.1.2**

### **Decimal**

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as "R."

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

#### EXAMPLE

A transmitted value of 12.34 represents a decimal value of 12.34.

New note

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note the statement in the preceding paragraph that the decimal point and leading sign, if sent, are not part of the character count.

### A.1.3.1.3

#### Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is "ID."

### A.1.3.1.4

#### String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is "AN."

### A.1.3.1.5

#### Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is "DT." Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

### A.1.3.1.6

#### Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is "TM." The length of the data element determines the format of the transmitted time.

#### EXAMPLE

Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

## IMPLEMENTATION

## FUNCTIONAL GROUP HEADER

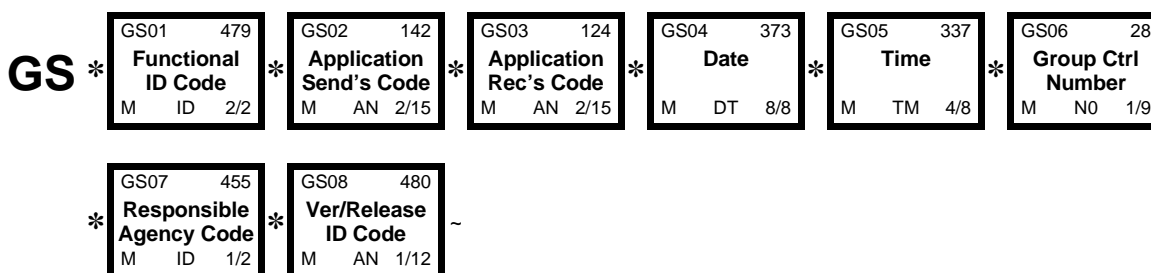
Example: **GS\*HC\*SENDER CODE\*RECEIVER  
CODE\*19940331\*0802\*1\*X\*004010X098A1~** ——— Example Changed

## STANDARD

**GS** Functional Group Header

**Purpose:** To indicate the beginning of a functional group and to provide control information

## DIAGRAM



## ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	GS01	479	<b>Functional Identifier Code</b> Code identifying a group of application related transaction sets	M	ID	2/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>HC</td><td>Health Care Claim (837)</td></tr></table>	CODE	DEFINITION	HC	Health Care Claim (837)			
CODE	DEFINITION									
HC	Health Care Claim (837)									
REQUIRED	GS02	142	<b>Application Sender's Code</b> Code identifying party sending transmission; codes agreed to by trading partners	M	AN	2/15				
			Use this code to identify the unit sending the information.							
REQUIRED	GS03	124	<b>Application Receiver's Code</b> Code identifying party receiving transmission. Codes agreed to by trading partners	M	AN	2/15				
			Use this code to identify the unit receiving the information.							
REQUIRED	GS04	373	<b>Date</b> Date expressed as CCYYMMDD	M	DT	8/8				
			SEMANTIC: GS04 is the group date.							
			Use this date for the functional group creation date.							
REQUIRED	GS05	337	<b>Time</b> Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	M	TM	4/8				
			SEMANTIC: GS05 is the group time.							
			Use this time for the creation time. The recommended format is HHMM.							

REQUIRED	GS06	28	<b>Group Control Number</b> Assigned number originated and maintained by the sender	M	NO	1/9				
			SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.							
REQUIRED	GS07	455	<b>Responsible Agency Code</b> Code used in conjunction with Data Element 480 to identify the issuer of the standard	M	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>X</td><td>Accredited Standards Committee X12</td></tr></table>	CODE	DEFINITION	X	Accredited Standards Committee X12			
CODE	DEFINITION									
X	Accredited Standards Committee X12									
REQUIRED	GS08	480	<b>Version / Release / Industry Identifier Code</b> Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed	M	AN	1/12				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>	CODE	DEFINITION					
CODE	DEFINITION									

New Code Value Added

**004010X098A1 Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.**

This is a Draft Addenda to the X12N 004010X098 Implementation Guide published in May 2000 and not yet intended for implementation. Since the 004010X098 guide is named for use under HIPAA, this Draft Addenda must go through a Notice of Proposed Rule Making (NPRM) process, just as the original Implementation Guide did, before becoming a final addenda to the guide published by X12N. Only the modifications noted in this Draft Addenda will be considered in the NPRM. Once this Draft addenda is approved for publication by X12N, the value used in GS08 will be "004010X098A1".